

US Business Leadership Network®  
Disability Supplier Diversity Program®  
1310 Braddock Place, Suite 101  
Alexandria, VA 22314



### Physician's Certification of Disability Form

The Standards and Procedures of the USBLN® Disability Supplier Diversity Program® enable individuals with disabilities to have their businesses obtain Disability-Owned Business Enterprise Certification. In order for a firm to become certified, it must first be determined that the owner(s) is (are) individual(s) with disabilities. The USBLN® Disability Supplier Diversity Program Standards and Procedures define disability with respect to an individual, as:

- a. **A physical and/or mental impairment that substantially limits one or more major life activities of such individual**, and can be demonstrated by appropriate documentation (e.g., records, statements, or other appropriate information) issued from a licensed, registered or certified vocational rehabilitation specialist (i.e., State or private); any Federal agency, State agency, or an agency of the District of Columbia or a U.S. territory that issues or provides disability benefits; or from a licensed medical professional (e.g., a physician or other medical professional duly certified by a State, the District of Columbia, or a U.S. territory, to practice medicine) that state that the individual is a person with a disability.
- b. A **Service-Disabled Veteran** is a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable, and whose **disability was incurred or aggravated in line of duty in the active military, naval, or air service**. To be considered a Service-Disabled Veteran, the veteran must have an adjudication letter from the Veterans Administration (VA), a Department of Defense Form 214 (Certificate of Release or Discharge from Active Duty), or a Statement of Service from the National Archives and Records Administration, stating that the veteran has a service-connected disability.

#### **Instructions to submit this form:**

1. **The applicant (individual with a disability) shall complete the self-indication section of this form and submit it to the certifying physician.**
2. **The certifying physician shall complete the form with comments and return the form to the applicant (individual with a disability).**
3. **The applicant (individual with a disability) includes the completed form with the certification application. To promote confidentiality of information, the form may be submitted in a sealed envelope marked "Physician's Certification of Disability Form".**

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**THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL WITH A DISABILITY (Self-indication):**

Full Legal Name of Applicant Business

Entity: \_\_\_\_\_ Full Name of Individual:

Signature: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Disability or Disabilities:

1. \_\_\_\_\_

\_\_\_\_\_ 2.

\_\_\_\_\_ 3.

Self-indication of functional limitations (for example, regularly requires the use of assistive technology to move physically around the community; unable to lift or carry 10 pounds or more; requires assistance for personal needs; etc)

- Mobility
- Communication
- Self-Care
- Self-Direction
- Interpersonal skills
- Work Tolerance
- Work Skills
- Other:

\_\_\_\_\_  
Please describe the probable duration of the limitations and whether a prognosis for recovery can be made:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**THIS SECTION TO BE COMPLETED BY PHYSICIAN:**

Name of Certifying Physician

(Printed): \_\_\_\_\_

Physician's Telephone

Number: \_\_\_\_\_

Physician's Business Address: \_\_\_\_\_

Professional Medical License

Number: \_\_\_\_\_

Patient Name:

Date of Onset of Disability

(MM/DD/YYYY): \_\_\_\_\_

**Does the above self-indication of disability (or disabilities) completed by the patient accurately describe the condition(s) and functional limitation(s) of the patient?**  Yes  No

If **yes**, please provide any additional information

that would support the patient's eligibility for disability status under the definition provided on page 1 of this document: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If **no**, please explain the condition(s) and functional limitation(s) of the patient. Please also provide any additional information that would support or disqualify the patient's eligibility for disability status under the definition provided on page 1 of this document: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I \_\_\_\_\_ (printed name of physician) certify that the individual patient/applicant named above meets the USBLN® Disability Supplier Diversity Program definition of disability as defined in this document and that all of the statements made above and any attached information are true and correct. I understand that submitting and/or attesting to any false information on behalf of an individual applicant could result in the revocation of any falsely acquired USBLN® certification of the above individual applicant and/or could result in legal action against the individual applicant and/or physician in accordance with applicable laws and penal codes.

Signature of Certifying

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_