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Doctor's Certification of Medical Need for Stairlift/Platform Lift

Patient's Name: _____

Date of Birth: _____

Doctor's Name: _____

License Number: _____

Doctor's Address: _____

Doctor's Phone: _____

Certification Statement:

I certify that the individual named above has a physical disability that makes it unsafe or impossible to ascend or descend stairs without assistance. To improve the individual's access and mobility within their residence, a stairlift or platform lift is recommended as medically necessary.

Date of Certification: _____

Doctor's Signature: _____