**“No Harm”: Physician Certification**

**(pursuant to CT PHC, Section 19-13-D13)**

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| --- | --- | --- | --- |
| **Patient’s Name:** |  | | |
| **Referral Source:** |  | | |
| **Patient’s Date of Birth:** |  | **Patient’s Gender:** |  |
| **Patient’s Present Location:** |  | | |
| **Patient’s Responsible Party:** |  | | |
| **Patient’s Diagnoses:** |  | | |
| **Patient’s Prognosis:** |  | | |
| **Patient’s Known Previous Psychiatric Hospitalizations:** |  | | |

**CERTIFICATION PURSUANT TO CPHC Section 19-13-D13**

1. The Patient has been evaluated by the undersigned,
2. The undersigned is a physician licensed to practice medicine and surgery in Connecticut who has completed graduate residency training approved by the American Board of Psychiatry and Neurology,
3. It is the opinion of the undersigned that the applicant may be cared for in a chronic and convalescent nursing home, without injury to the patient or persons or property
4. The undersigned hereby recommends that the applicant may be appropriately cared for in a licensed chronic and convalescent nursing home.

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| Additional Information, if needed: |

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**Physician’s Signature DATE**