# Doctor's Certification of Disability form

CITY OF CERRITOS | CERRITOS ELECTRIC UTILITY | DEPARTMENT OF PUBLIC WORKS / WATER AND POWER | (562) 916-1221 | power@cerritos.us

*A full, legible description of the illness or disability must be provided for numbers 3, 4, 5, 6 and 7 below. A licensed physician or surgeon may certify to items 1–7. A licensed chiropractor may certify to items 5–7 only, and a licensed physician or surgeon who specializes in diseases of the eye or a licensed optometrist may only clarify to item 8.*

My patient ________________ meets the requirements of a disabled person as found in the California Vehicle Code 295.5 as he or she suffers from the following:

- ☐ 1. A lung disease to the extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter or arterial oxygen tension (pO2) is less than 60mm/Hg on room air while the person is at rest.
- ☐ 2. A cardiovascular disease to the extent that the person's functional limitations are classified in severity as Class III or Class IV based upon standards accepted by the American Heart Association.
- ☐ 3. A diagnosed disease or disorder which substantially impairs or interferes with mobility due to (please print): ________________
- ☐ 4. A severe disability in which he or she is unable to move without the aid of an assistive device, which is due to (please print): ________________
- ☐ 5. A significant limitation in the loss of lower extremities due to (please print): ________________
- ☐ 6. The loss, or loss of the use of one or more lower extremities. Loss of use due to (please print): ________________
- ☐ 7. The loss, or loss of the use of, both hands. Loss due to (please print): ________________
- ☐ 8. Central visual acuity does not exceed 20/200 in the better eye, with corrective lenses, as measured by the Snellen test, or visual acuity that is greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.

## Doctor's Signature and Certification

Doctor's Name: First ________ Middle ________ Last ________

Phone Number: ________________

Address: Address ________ City ________ State ________ Zip ________

***I certify that I am a ☐ Physician ☐ Surgeon ☐ Chiropractor ☐ Optometrist and I certify under penalty of perjury of the laws of the State of California that the information that I have provided is true and correct and that I will retain information sufficient to substantiate this certification and shall make that information available for inspection by the Medical Board of California at the request of the City of Cerritos.***

| Executed at (City, State) | Date |
|---|---|
| Doctor's Signature | Doctor's Medical License Number |