

PHYSICIAN'S CERTIFICATION THAT
TREATMENT WOULD BE MEDICALLY INEFFECTIVE

A. Certification by the Attending Physician

I, _____ M.D., as the Attending Physician for _____ (Resident), have examined _____ (Resident) on _____ (Date) at _____ (Time). Based on this examination, I hereby certify that due to the Resident's condition which is _____, the following treatment(s) _____ which, under generally accepted medical practices are life-sustaining in nature, are being withheld because, to a reasonable degree of medical certainty, the treatment would not prevent or reduce the deterioration of the Resident's health or prevent the impending death of the Resident.

I further acknowledge that I have informed () the Resident, () the Resident's Agent, or () the Resident's surrogate of my decision to withhold treatment on the basis that it would be medically ineffective.

Date: _____

Signature of Attending Physician

Date: _____

Name of Attending Physician

B. Certification by a Second Physician

I, _____ M.D., have examined _____ (Resident) on _____ (Date) at _____ (Time). Based on this examination, I hereby certify that due to the Resident's condition which is _____, the following treatment(s) _____ which, under generally accepted medical practices are life-sustaining in nature, are being withheld because, to a reasonable degree of medical certainty, the treatment would not prevent or reduce the deterioration of the Resident's health or prevent the impending death of the Resident.

Date: _____

Signature of Physician

Date: _____

Name of Physician