

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