

**Statement of Certifying Physician for Therapeutic Shoes**

Patient Name: \_\_\_\_\_

HIC #: \_\_\_\_\_

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
  - a) History of partial or complete amputation of the foot
  - b) History of previous foot ulceration
  - c) History of pre-ulcerative callus
  - d) Peripheral neuropathy with evidence of callus formation
  - e) Foot deformity
  - f) Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

\_\_\_\_\_

Physician address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician UPIN: \_\_\_\_\_