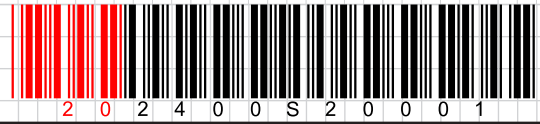




Enter your last name XXXXXXXXXXXXXXXXXXXX  
Enter your TIN 999999999



Government of the District of Columbia

# 2020 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer  
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Taxpayer identification number (TIN)  
999999999

I certify that the above taxpayer was permanently and totally disabled when the taxpayer retired. (Enter retirement date.)MM DD YYYY

Physician's first name, middle initial, last name  
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

99999999

Physician's address (number and street)  
9XXXX9XXXX9XXXX9XXXXXXXXXXXXXXXXXXXX

Suite number  
9XXXX

City  
XXXXXXXXXXXXXXXXXXXX

State  
XX

Zip Code + 4  
99999999

Physician's phone number  
9999999999

Physician's signature

Date (MMDDYYYY)  
99999999

Attach to Form D-40. See instructions.

DRAFT  
2020