[FACILITY NAME]
Delayed Physician Certification / Recertification

Patient Name: _____

Medical Record Number: _____

Admission Date: _____

Discharge Date:_____

Reason for Delayed Certification / Recertification: *(i.e. Oversight; Form inadvertently not flagged for physician signature / completion.)*

Certification / Recertification: Inpatient skilled nursing services were required for the above named patient from _____ through_____ because of his/her need for continuing treatment for: _____ _____. This is a condition for which this patient was treated or which arose in a hospital stay that ended on the discharge date noted above. This patient a) was discharged to:

_____

or b) expired on the discharge date noted above *(Please cross out or circle "a)" or "b)" as circumstances apply and indicate where the patient was discharged to if applicable).*

Details of the patient's condition, skilled services, need for continuing care, and the discharge summary can be found in the patient's medical record. I have reviewed that record and attest that the medical record supports the need for continuing care in the Skilled Nursing Facility and contains plans for home care if appropriate.

Signed:_____

Date:_____