Coastal
Health Systems of Brevard
ALS, BLS, SCT

PHYSICIAN CERTIFICATION STATEMENT (PCS)

PATIENT NAME:

DATE OF SERVICE:

TRANSPORT ORIGIN:

TRANSPORT DESTINATION:

I certify that the above patient was ALL of the below:

- Unable to get up from bed without assistance, **AND**
- Unable to ambulate, **AND**
- Unable to sit in a chair or wheelchair **AND**
- Needed to be transported by ambulance due to his/her medical condition

ATTENDING PHYSICIANS
SIGNATURE_____

DATE _____

PRINT NAME OF PHYSICIAN_____

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