

**DISTRICT OF COLUMBIA JUDICIAL NOMINATION COMMISSION
MEDICAL CERTIFICATION**

(To be completed by your primary health care provider.)

Judge's Name:

Date of Birth:

I _____ certify that I have examined Judge _____
on _____ and find him/her physically and mentally fit to perform judicial
duties.

OR

I _____ certify that I have examined Judge _____
on _____ and find him/her physically and mentally fit to perform judicial
duties with the following limitations:

Attach additional information, if any.

OR

I _____ certify that I have examined Judge _____
on _____ and the process of evaluation is not complete.

OR

I _____ certify that I have examined Judge _____
on _____ and do not find him/her physically and/or mentally fit to
perform judicial duties for the following reasons:

Attach additional information, if any.

Signature of Doctor

Address of Doctor

Telephone Number of Doctor

Please Return Completed Form To:
District of Columbia Judicial Nomination Commission
515 5th Street, NW, Suite 235
Washington, DC 20001