110 Cleveland Drive
Paris, KY 40361
1-800-782-6823
Fax: 859-256-3125

CERTIFICATION OF POST-TRAUMATIC STRESS INJURY OR POST-TRAUMATIC STRESS DISORDER DIAGNOSIS

I, ___________________________, hereby certify that I am a licensed mental health professional
Name of Licensed Mental Health Professional

at _______________________________, located at _____________________________________,
Name of Provider/Facility/Organization Address

_______________________, ______ ___________.
City State ZIP Code

I hereby certified that I have treated, evaluated, and/or counseled _________________________
Name of Firefighter

and he/she was diagnosed with post-traumatic stress injury or post-traumatic stress disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, on __________________________. I further certify that the above-named current or
Date of Diagnosis

former professional or volunteer firefighter's post-traumatic stress injury or post-traumatic stress disorder has been caused by an event or an accumulation of events that occurred in the course and scope of his or her position as a professional or volunteer firefighter in the Commonwealth of Kentucky.

_____________________________________ _________________
Signature of Certified Mental Health Professional Date