Physician's Statement of Diagnosis

I hereby certify that my patient, _____
Patient's full name Patient's D.O.B.

is being treated for the following condition(s): _____

_____

and/or suffers from the following symptoms : _____

_____

Physician Information

Name (block letters): _____

License Number: _____

Telephone: _____
Office # Fax #

Office Address: _____

_____

_____

□ I understand my office may be contacted to confirm this information.

_____
Physician signature Date

Notes : _____
_____
_____
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