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: ____

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

____

Physician signature　　　　　　　　Date

Notes : ____

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