Physician's Statement of Diagnosis

I hereby certify that :_____ _____
first name last name

_____
date of birth

is my patient and is presently being treated for the following condition(s) :

_____

_____

and/or suffers from the following symptoms :

_____

_____

_____

☐ I understand that my office might be contacted to confirm the authenticity of this information.

Date : _____

Name of physician :
(Please use block letters) _____

Physician's signature : _____

Physician's license number : _____

Telephone : ( ) _____ — _____

Address : _____

_____

Notes : _____

_____

_____

_____