

MEDICAL INFORMATION

PATIENT INFORMATION

LAST NAME

GIVEN NAME(S)

DATE OF BIRTHDAY

HOME ADDRESS

APT / STREET NUMBER

STREET NAME

CITY OR TOWN

PROVINCE

POSTAL CODE

COUNTRY

PATIENT'S SIGNATURE

PATIENT'S SIGNATURE

DATE

MEDICAL INFORMATION

THIS PART TO BE COMPLETED BY PHYSICIAN ONLY

PHYSICIAN'S NAME

PHYSICIAN'S ADDRESS (INCLUDING CITY, POSTAL CODE)

PHONE NUMBER

FAX NUMBER

APPLICANT'S DIAGNOSIS

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient has a life expectancy of eighteen months or less OR my patient could not actively participate in the requested Experience beyond the next eighteen months. I certify that my patient is of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the Experience request with my patient and as of the circumstances and patients condition at this time, deem it safe and reasonable if his/her Experience to be granted within the next three to six months.

SIGNATURE OF PHYSICIAN

TITLE

DATE
