MEDICAL STATEMENT

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)

1. PATIENT'S INFORMATION

Name	Last	First	M.I		
Date of birth	MM / DD / YY	Height ☐ M ☐ Ft		Weight ☐ Kg ☐ Lb	

2. MEDICAL HISTORY

Please provide details about when the condition was diagnosed:

Date of first visit	Symptoms	
MM / DD / YY		

Diagnosis

Prognosis

Treatment

Other comments

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? ☐ Yes ☐ No
If "Yes", please provide the information requested below.

Physician's name		Telephone	
Out-patient treatment			
Hospital		Telephone	
Hospital treatment			

3. TREATING PHYSICIAN'S INFORMATION					
Name					
Address					
Telephone		Fax number		Email	
Date	MM / DD / YY	Signature			

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