Doctor / Physician Verification Form

Patient Information

To receive assistance, all of the information below must be completely filled out and returned by the treating physician.

Applicant Name:		**Birth Date:**	
Date of Diagnosis:		**Diagnosis:**	
Current Prognosis:	☐ Good ☐ Fair ☐ Serious ☐ Critical		
Current Treatment Plan:	☐ Monitored / Maintenance		
Current Treatment Duration (from today):	☐ 3-6 months ☐ 6-12 months ☐ 12-18 months ☐ 2 years +		
Frequency to hospital/clinic for current treatment:	☐ Monthly ☐ Bi-weekly ☐ Weekly ☐ Daily		
Other Comments:			

Physician's Name _____ **Physician's Signature** _____ **Date** _____

Physician's Address _____ **City, State/Zip** _____ **Phone #** _____

Nurse/Case Manager Name _____ **Email Address** _____ **Phone #** _____

By signing below, I, _____ (parent/guardian of minor) give my permission to release diagnosis or treatment information for my child, _____ (minor).

Parent/Guardian Name _____ **Parent/Guardian Signature** _____ **Date** _____

Physician's office must mail or fax completed form to:

The Let It Be Foundation, Inc.
14720 Central Ave
Chino, CA 91710
Ph: (909) 613-9161
Fax: (909) 627-6735
www.theletitbefoundation.org