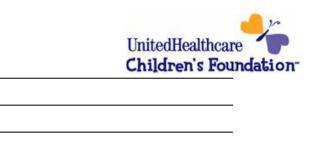


## **Physician's Certification of Medical Condition**

Child's Name: Child's Date of Birth:	
Parent/Legal Guardian Name:	
Parent/Legal Guardian Signature:	
<u>Parent/Legal Guardian</u> : After your child's physician has completed this form, please attach it to child's online application. You may do this by scanning a copy to your computer, or by taking a each side of the form and attaching them.	
Child's Medical Information (To be completed by the child's physician)	
NOTE: Physician <u>must</u> be an M.D., D.O., or for hearing-related conditions, an Au.D.  The parent/legal guardian of the child listed above has applied for a medical grant with the UnitedHeals Children's Foundation (UHCCF). Please complete the following medical information.	thcare
Child's Primary Diagnosis:	
Child's Secondary Diagnosis (if applicable):	
How are the current diagnoses impacting the child's life? (check all that apply):  ☐ Medically ☐ Socially	
☐ Psychologically/Behaviorally ☐ Other:	
I recommend the following (indicate and describe all that apply) and describe why they are needed:  ☐ Medical and/or Surgical Treatments or Procedures:	
□ Durable or Disposable Items/Equipment:	
☐ Therapy(ies):	
If recommended therapy is a drug, formula or medical food, has the manufacturer's representation contacted for assistance? Please provide details:	ntive been



☐ Other:	Children's rou
	S:
	hi/t
Has the child previously received these t	herapies/treatments?
If yes, have they been effective?	
Additional Notes/Comments:	
Physician Information – Items marked	with an (*) are required in order to process form.
*Physician Name:	
Provider I.D. #:	Telephone:
Address:	
*Signature:	*Date:

<u>Physician:</u> Thank you for taking time to complete this information. Please return this form back to the child's parent and/or legal guardian so that they may attach it to their child's grant application.