THE Granted Wish FOUNDATION

c/o 604 35th St. NW Canton, OH 44709 | Email: scoletti@grantedwish.org | www.grantedwish.org

Medical Authorization Form

Must Be Completed By The Nominee's Treating Physician

1. **Patient's Name:** _____

2. **Patient's DOB:** _____ **Date Of Patient's Last Visit:** _____

3. **Patient's Diagnosis:** _____

4. **Is This Diagnosis Considered Life Threatening?** ☐ **YES** ☐ **NO**

5. **Patient's Prognosis:** _____

6. **Any Other Pertinent Information?** _____

_____

_____

I hereby certify that I am the treating Physician of this patient. I have completed the requested information or have authorized a qualified staff member to do so on my behalf.

_____ _____

Physician's Name **Date**

_____ _____

Physician's or Staff Representative Signature **Physicians' Office Phone No.**

_____

Physician's Name Of Practice or Affiliated Hospital *(If Applicable)*

_____

Physician's Office Address

You Can Scan & Email This Form To: scoletti@grantedwish.org
Or You May Send It Through Postal Mail To The Address Above