PHYSICIAN AUTHORIZATION FOR NON-AMBULATORY RESIDENT

_____	_____
Resident's Name	***Date of Birth***

I, _____ provide authorization for my non-ambulatory patient to reside at _____ with the best of intentions for the patient.

Please note that ARS requires the facility to obtain a Physician Signature every 6 months. A visit by the physician must be made during this time. Thank you for your assistance.

_____	_____
Physician Signature	Date
_____	_____
Physician Printed Name	Date
_____	_____
Manager's Signature (or Authorized)	Date