Physician Certification of Medical Condition

Patient Information (*To be completed by the Patient/family Member*)

1: Patient's Name:_____**Patient's Date Of Birth**_____

If the patient is a child or unable to fill out his/her form, please print the name of the parent or family member completing this form on line 1B.

1B: **Name**:_____**Relationship to Patient**:_____

Patient/Parent/family member Signature: _____

After your physician has completed this from, please attach it to your online application. You may do this by scanning a copy to your computer, or by taking a picture of the form and upload it.

Patient's Medical Information: (To be completed by the Primary Care Physician)

NOTE: Physician must be licensed and practicing in your country.

**The Patient (Parent/ Family member of the patient) listed above has applied for medical assistance with Medical Professionals On a Mission Inc (MPOM). Please complete the following medical information.*

1) Patient's Primary Diagnosis:_____

2) Patient's secondary Diagnosis (if applicable)_____

3) How are the current diagnosis impacting the patient's life? (check all that apply)

□ Medically

□ Socially

□ Psychologically/ Behaviorally

□ Other:_____

4) I recommend the following (indicate and describe all that apply) and describe why they are needed:

□ Medical and /or Surgical Treatments or Procedures:_____

_____

_____

□ Therapy(ies): _____

_____

5) The goal of these therapies/ treatment is: _____

_____

6) Has the patient previously received these therapies/treatments? _____

_____

7) If yes, Have they been effective? _____

_____

Additional Notes/Comments:_____

_____

_____

Physician Name:_____

*__Title:__**_____**

Provider I.D#:_____

Address:_____

_____

Telephone:_____

Email:_____

***__Signature:__**_____ **Date:_____**