MULTIPLE SCLEROSIS FOUNDATION

HEALTH AND WELLNESS PROGRAM
DOCTOR'S CONFIRMATION FORM

Please fill out this form and take it to your doctor to sign and date. We will need your doctor to confirm your MS diagnosis, and to verify that you are able to participate in the program. This form needs to be returned to the MSF in order to attend the program.

Patient's Name: _____
(Please print name & address)

Address: _____

Phone: _____

Type of Program/Service: _____

Doctor's Name: _____
(Please print name & address)

Address: _____

Phone: _____

Fax: _____

Doctor's Signature Required:

I can confirm that this patient has multiple sclerosis and can participate in this program.

_____
(Doctor's Signature) (Date)

All information obtained will be held in strict confidence and we will respect your privacy.

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