

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. Is The Patient' Cleared For Travel if Necessary? YES NO

7. 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 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: wishes@grantedwish.org
Or You May Send It Through Postal Mail To The Address Above