THE Granted Wish FOUNDATION

c/o 604 35th St. NW Canton, OH 44709 | Office Phone: 330-244-9474 | 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. **Patient's Prognosis:** ____

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

   Additional Information On Travel? ____
   ____

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 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)*

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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