3 LITTLE BIRDS 4 LIFE
PO Box 187 - Collinsville, IL 62234

Physician Verification Form

This Form To Be Filled Out By Physician Only

Patient's Name and Birthdate: _____

Physician's Name: _____

Physician's Address: (Including City/State/Zip) _____

_____

Phone Number: _____

Fax Number: _____

Applicant's Diagnosis and Stage: _____

Is the Wish Recipient currently in Active Treatment? _____

If No, when was the date of last Active Treatment? _____

I certify that I am the treating physician of the Applicant. To the best of my knowledge, the patient is of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the wish request with my patient and have deemed it safe and reasonable if his/her wish is granted.

_____ _____

Physician Only Signature Date

**Please have the Physician fax this page to: 3 Little Birds 4 Life at 618-845-6031