Doctor's Verification Form

This letter is to confirm that_______________________________________ was diagnosed

With ____________________________________ on this date___________________.

His/her current prognosis is: ___good ___fair ___serious ___critical

Current Treatment Plan: ____

____

____

Current Treatment Duration: ___3-6months ___1year ___2years+

Frequency to hospital/clinic for his/her current treatment:
___ monthly ___ bi-monthly ___ weekly ___ daily

Other comments: ____

____

____
Physician's Name Physician's Signature Date

____
Physician's Address City State/Zip Phone Number

* All the above information must be filled out completely to receive assistance

I, ____ give my permission to release
(Parent/Guardian of minor)

Diagnosis information of my child, ____.

____
Parent/Guardian Signature Print Name Date

*Physician's office must mail in corporate envelope or fax completed form to:

The Let It Be Foundation, Inc.
P.O. Box 730
Chino Hills, Ca 91709
909.613.9161 office
909.627.6735 fax