MEDICAL DIAGNOSIS ATTESTATION FORM

(Please complete legibly in black or blue ink.)

I, the undersigned physician, attest that the patient specified below is diagnosed as set out in this form as of the date of this attestation.

Patient Full Legal Name: _____

Patient DOB: _____

Last Four of Patient's SSN: _____

Diagnosis:
(Check all that apply.)

- ☐ Acquired immune deficiency syndrome
- ☐ Anxiety Disorder
- ☐ Autism Spectrum Disorder
- ☐ Autoimmune Disease
- ☐ Anorexia Nervosa
- ☐ Cancer
- ☐ Dependence upon or addiction to opioids
- ☐ Glaucoma
- ☐ A medical condition or treatment for a medical condition that produces, for a specific patient, one or more of the following cachexia; muscle spasms, including, without limitation, spasms caused by multiple sclerosis; seizures, including, without limitation, seizures caused by epilepsy; nausea; or severe or chronic pain
- ☐ A medical condition related to the human immunodeficiency virus
- ☐ A neuropathic condition, whether or not such condition causes seizures
- ☐ Post-traumatic stress disorder
- ☐ Crohn's disease
- ☐ Sickle cell anemia
- ☐ Amyotrophic lateral syndrome
- ☐ Parkinson's disease
- ☐ A condition resulting in the patient receiving Hospice care
- ☐ A terminal illness resulting in life expectancy of less than six months

Other Diagnosis Information:
(If applicable.)

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Physician Signature: _____

Name of Physician: _____

Date: _____ State of License: _____

License #: _____

Rev. 3/2023