 Medical Condition Verification Form 

I hereby confirm that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Patient Name) Please Print

is being treated for a medical condition that requires routine visits, prescription maintenance, and/or regular testing and is in compliance with these standards of care for **at least 6 months**.

**(Provider please sign and provide ALL dates to show compliance for at least 6 months.)**

Provider Signature Printed Name Dates of

Exams, Testing, etc

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Exam |  |  |  |
| Prescription Compliance |  |  |  |
| Labs |  |  |  |
| Testing (CT, X-ray, etc) |  |  |  |
| Other exams  Eye, foot, hearing, etc. |  |  |  |

**Patient Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School or College:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_