FORWARD
FOUNDATION

MEDICAL INFORMATION

PATIENT INFORMATION

LAST NAME

GIVEN NAME(S)

DATE OF BIRTH

HOME ADDRESS

APT / STREET NUMBER

STREET NAME

CITY OR TOWN

PROVINCE

POSTAL CODE

COUNTRY

PATIENT'S SIGNATURE

I authorize my doctor or nurse practitioner to release my medical information to Forward Foundation

PATIENT'S SIGNATURE

DATE

FORWARD FOUNDATION

MEDICAL INFORMATION

THIS PART TO BE COMPLETED BY PHYSICIAN ONLY

PHYSICIAN'S NAME

PHYSICIAN'S ADDRESS (INCLUDING CITY, POSTAL CODE)

PHONE NUMBER

FAX NUMBER

APPLICANT'S DIAGNOSIS

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient has a serious and significant, life-limiting illness. I certify that my patient is of sound mind, and capable of signing legal documents. I have discussed (or will discuss) the Experience request with my patient. Given the patient's condition at this time and the anticipated experience, I deem it safe and reasonable if his/her Experience is granted within the next three to six months.

SIGNATURE OF PHYSICIAN

TITLE

DATE