Physician Attestation

Please complete and return this signed form with your grant application.

To be completed by the patient's attending physician:

Name of patient: _____ Patient DOB: _____

Medical diagnosis: _____

Is the patient's diagnosis considered a life-threatening critical illness or critical injury as defined below? **Yes**__ **No**__

Critical illness or critical injury is defined as a life-threatening medical condition which requires a person to be under the active care and treatment of a physician which require periodic visits for treatment that continue over an extended period of time and may cause episodic incapacity (inability to work or perform other regular daily activities due to the serious health condition), e.g., heart attack, stroke, cancer, end-stage renal disease, major third-degree burns or paralysis.

Please explain why this medical diagnosis is life-threatening.

_____

_____

_____

_____ _____

Physician name (please print) Physician phone number

_____ _____

Physician signature Date

If the patient is not an employee of LHC Group, please indicate the patient's relationship to the employee:

- ☐ Spouse
- ☐ Domestic partner
- ☐ Child
- ☐ Step-child
- ☐ Child whom the employee has parenting responsibilities

I authorize the Purpose Fund to confirm my medical diagnosis with my physician and understand the information in this physician's attestation will be used to determine qualifying criteria for grant consideration from the Purpose Fund.

_____ _____

LHC Group employee signature Date