Physician's Verification Form

Please ask your physician to complete the information in the form below.

To Be Completed by Patient's Doctor	
Name of Patient:	
Patient Diagnosis:	**Date of Diagnosis:**
Is Patient In Active Treatment? YES ☐ NO ☐	
When Did/Will Treatments End?	
Provider Name:	**Hospital/Clinic:**
Address:	**City/State/Zip:**
Phone:	
Provider Signature:	**Date:**
Additional Comments:	

Completed and Signed Form can be returned as follows:

1. Give to Patient to forward
2. Scan and email to: pafinfo@lbhn.org
3. Mail to: LBHN/PAF Program
   P.O. Box 6154
   Leesburg, VA 20178