

Housing Authority Letterhead

Name of Physician _____

Physician's Address _____

Date _____

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

Applicant's Name

Control No. _____

Applicant's Address

I hereby authorize release
of the requested information.

Applicant's Signature

Dear Dr. _____:

The above named applicant is seeking state-aided housing with this Authority and has indicated that he/she is being displaced or has been displaced from his/her current housing because of a severe medical emergency.

In order to determine whether to grant priority status for this applicant, we must secure verification of a qualifying severe medical emergency. Therefore, we would appreciate your completing the verification on the reverse and returning this form directly to the Housing Authority. A representative of the Authority may contact you at a later date to confirm the information.

Sincerely,

Executive Director or Tenant Selection Coordinator

Medical Emergency Verification (November) 11/2000

EQUAL HOUSNG OPPORTUNITY

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

1. Is the applicant or member of the applicant's household suffering from an illness or injury which poses a severe and medically documented threat to life or safety? (circle one)

YES NO NO OPINION

If YES, please explain: _____

2. Is the applicant's current housing situation a cause of the illness or injury or is it a substantial impediment to treatment or recovery from this illness or injury? (circle one)

YES NO NO OPINION

If YES, please explain: _____

3. How long has the applicant or household member been your patient? _____

4. For what are you currently treating the patient? _____

PHYSICIAN'S CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____, MD
Signature

Date

Name: _____

Address: _____

Telephone: (____) _____