PHYSICIAN'S STATEMENT

FROM: PHYSICIAN: (print) ____
Street address: ____
City, State, Zip Code: ______________________________________
Telephone number: _______________________________________
Fax number: ____

TO: Path of Hope, Inc.
PO Box 1824
Lexington, NC 27293
Telephone number: (336)248-8914
Fax number: (336) 248-2138

I HAVE EXAMINED THIS PATIENT:
Name: (print) ____
Date of Birth: ____
Social Security Number: ___________________________________

AND FOUND THAT HE/SHE IS PHYSICALLY FIT AND ABLE TO FULLY PARTICIPATE IN THE PROGRAM AT PATH OF HOPE, INC. I HAVE ALSO FOUND THIS PERSON IS CAPABLE TO SELF ADMINISTER OVER THE COUNTER MEDICATIONS AS DIRECTED BY PRODUCT INSTRUCTIONS AND MAY SELF ADMINISTER THE FOLLOWING PRESCRIPTION MEDICATIONS AS DIRECTED ON PRESCRIPTION CONTAINER:

Name of medication (print)	Strength	How often?
____________________	_________	___________
____________________	_________	___________
____________________	_________	___________
____________________	_________	___________
____________________	________	___________
____________________	_________	___________

<u>Physician Signature Only</u>: _________________________ Date: ___________