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 she is physically fit to participate in the Substance Abuse Treatment Program at Path Of Hope Inc. I have also found that this person is capable of self administering Over the Counter medications as directed by product instructions and the prescribed medications listed below. ***Note, client cannot be prescribed or given any opiates or benzodiazepines. Please list all medications given while client was in your facility.***

Medications Given	Dosage	Frequency
Medications Prescribed		

***Due to N.C. State regulations we are not allowed to let clients at Path Of Hope Inc. take anything that is medicated without a Doctor's Signed Authorization, this includes both Prescribed and Over the Counter medications. It would be greatly appreciated if this form could be signed in order to allow the above named client to take both the prescribed medications listed above and OTC's if a need should arise.**

Physician Signature Only: _____ Date: _____