**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:

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:

Strength

How often?

**Physician/NP/PA Signature Only**:

Date:



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

Name of medication (print)