THE SUSIE FOUNDATION

This page must be signed by a physician, neurologist, or social worker experienced in either diagnosing, administering care, and/or coordinating services for persons living with ALS. This form should only be completed one time, therefore if you are re-applying for a Flex Grant you do not need to complete this form

Verification of Diagnosis

Patient Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Email: _____

ALS Clinic Attended: _____

To be completed by physician, neurologist, or social worker with knowledge of patient and diagnosis

By my signature below, I verify that I have diagnosed and/or am fully aware, knowledgeable, and fully supportive of the diagnosis of the above named individual with Amyotrophic Lateral Sclerosis (ALS).

Name: _____ Phone: _____

Signature: _____ Date: _____