MitoScholars and MitoScholars+
Proof of Diagnosis Form

PERSONAL INFORMATION - TO BE COMPLETED BY APPLICANT

Applicant's Full Name ______________________

Name of Health Care Provider ______________________

Hospital or Clinic Name ______________________

Street Address ______________________

City and Province ______________________ Postal Code ______________________

Office Phone ______________________ Healthcare Provider E-mail ______________________

Notes ______________________

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HEALTHCARE PROVIDER SECTION

This section to be completed by Healthcare Provider. Please confirm:

- ❑ this applicant is your patient and has a mitochondrial disease diagnosis, or
- ❑ this applicant has a parent or sibling who has received a mitochondrial disease diagnosis.

I certify that either the applicant or the applicants parent/sibling is under my medical care and has been diagnosed with:

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Date ______________________ HCP Name ______________________

HCP Signature ______________________ ______________________