MitoRide

PROOF OF DIAGNOSIS FORM

PERSONAL INFORMATION - TO BE COMPLETED BY APPLICANT

Child/Youth's Full Name

Name of Health Care Provider

Hospital or Clinic Name

Parent's Full Name _____

Home Address _____

City and Province _____ **Postal Code** _____

Home phone/Cell _____ **Personal E-mail Address:** _____

Note:

A letter of diagnosis or other form of medical documentation outlining your child's mitochondrial disease diagnosis is an acceptable alternative to having a healthcare provider complete the section below.
The documents you choose to share are at your discretion. All documents shared will be kept private and confidential.

HEALTHCARE PROVIDER SECTION

This section **must** be completed by a healthcare provider (HCP).
Please provide the applicants mitochondrial disease diagnosis and year of diagnosis

I certify that this applicant is under my medical care and has been diagnosed with:

Dx _____

Date _____ **HCP Name** _____

HCP Signature _____