DiDonato Paralysis Grant Program
Medical Verification of Disability

The individual below may be eligible for a special grant from the DiDonato Paralysis Foundation (DPF).

Name of potential recipient:_______________________________ ______________________ ____
Last name First name
MI

Birth date (mm/dd/yyyy):__________________ Social Security# _____ _____ ______

I authorize you to release from your records any information regarding my medical and/or health conditions to the DiDonato Paralysis Foundation. All records maintained by the DPF pertaining to the named potential recipient are protected from disclosure and are subject to all other requirements of confidentiality. Participation with the DPF Grant Program is entirely voluntary; however, these records will be held in confidentiality at the DPF office and may be retrieved only by the named potential recipient after signing a release form.

Signature of potential recipient:_______________________________________ Date:_____________

Please name the Physician, Specialist, or Agency who can provide verification of your disability

Name:____

Title/Professional designation:____

Address, City, State, Zip:____

Phone #___________________________________ email address:____________________________

To the Physician/Specialist/Agency:

Please check all of the following that apply to the potential recipient's disability. It would also be helpful if you would list the degree, progressive factors involved, and/or any limiting effects of the disability. Such documentation may be provided in the space below or by forwarding tests and other verification.
____
____
____

Diagnosis:____

Progressive
Factor(s)____
____

Medication(s):____
____

Side
Effects:____
_

Description of Functional Limitation(s):____

____

____

____ ____ ________________________________

____

Signature of Physician/Specialist Title/Position

Date