Housing Authority Letterhead

Name of Physician_____

Physician's Address_____
_____

Date_____

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

_____ Control No._____
Applicant's Name

_____ I hereby authorize release
Applicant's Address of the requested information.

_____
_____ Applicant's Signature

Dear Dr. _____:

The above named applicant is seeking state-aided housing with this Authority and has indicated that he/she is being displaced or has been displaced from his/her current housing because of a severe medical emergency.

In order to determine whether to grant priority status for this applicant, we must secure verification of a qualifying severe medical emergency. Therefore, we would appreciate your completing the verification on the reverse and returning this form directly to the Housing Authority. A representative of the Authority may contact you at a later date to confirm the information.

Sincerely,

_____
Executive Director or Tenant Selection Coordinator

PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

1. Is the applicant or member of the applicant's household suffering from an illness or injury which poses a severe and medically documented threat to life or safety? (circle one)

YES NO NO OPINION

If YES, please explain:_____
_____
_____
_____

2. Is the applicant's current housing situation a cause of the illness or injury or is it a substantial impediment to treatment or recovery from this illness or injury? (circle one)

YES NO NO OPINION

If YES, please explain:_____
_____
_____
_____

3. How long has the applicant or household member been your patient? _____

4. For what are you currently treating the patient?_____

PHYSICIAN'S CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____,MD _____
Signature Date

Name:_____

Address:_____

_____

Telephone: (____)_____

Medical Emergency Verification (November) 11/2000

EQUAL HOUSNG OPPORTUNITY