

alzheimer's  association®  
Midlands Chapter

Physician Statement

Please have your physician complete this statement as a part of your Application for Respite Care Reimbursement.

**PLEASE PRINT**

Name of Individual with dementia: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Caregiver Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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[www.alz.org/midlands](http://www.alz.org/midlands)