Confirmation Form
Patients Age 21+ in the Care of a Pediatrician or Pediatric Specialist

Physician Name:____
Last/Surname First Middle

Physician License Number: ________________________ **Physician Telephone Number:** _____________________

Physician Practice Address: ____

Physician Email Address:____________________________________

Patient Name: ____
Last/Surname First Middle

Patient Date of Birth: _________________________________

Patient Address: ____

City: __________________________ **State:** _______________ **ZIP Code:** ________________________

Patient Telephone Number: ____

CERTIFICATION OF PATIENT UNDER CARE OF PEDIATRICIAN

I hereby certify that I have a physician-patient relationship with the patient named above.

I attest that I am the physician listed above and the statements in this determination are true and complete.

Physician's Signature: ____ **Date:** ____________
MM/DD/YYYY