TEMPLATE LETTER FOR PHYSICIANS CONFIRMING A PATIENT'S NEED FOR PROXY VOTE ON AN AS-NEEDED BASIS FOR CLINICALLY DIAGNOSED MEDICAL CONDITION(S)

[Date]

To whom it may concern,

The purpose of this letter is to document a chronic medical condition(s) and/or disability that impairs daily activities for my patient, _____.
(First and last name of patient)

Should you have any questions, please do not hesitate to call my office at_____.

Respectfully submitted,

_____ Date:_____
Signature of provider or approved APRN

_____
Printed name of provider or approved APRN

Date received by Speaker of the House:_____

Received by:_____