



## United We Care Fund

### ***Attending Physician's Statement***

*This form is required for team members requesting funds for medical reasons.*

Name of Patient: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Dates hospitalized, if any:

Date Admitted: \_\_\_ / \_\_\_ / \_\_\_

Date Discharged: \_\_\_ / \_\_\_ / \_\_\_

To your knowledge, what is the earliest date the patient was treated for this condition?

\_\_\_\_\_

Is the patient still under your care? Yes    No

For what period of time will the patient be unable to work?

For what reason(s) would the patient need to miss work for this time period?

Projected date for patient to return to work: \_\_\_\_\_

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Typed or printed name of physician

\_\_\_\_\_  
Signature of Physician