Step 3 - Medical Information:

Dream Applicant's Signature: _____

This Part To Be Filled Out By Physician Only

Physician's Name:

_____

Physician's Address:

_____

(Including City/State/Zip)

Phone Number: (_____)_____

Fax Number: (_____)_____

Applicant's Diagnosis:

_____

Current Life Expectancy in MONTHS: _____

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient is of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the dream request with my patient and have deemed it safe and reasonable if his/her dream is granted within the next year.

Physician Signature Only

Signature:_____ **Date:**_____