MSU Myositis Support & Understanding
EMPOWERING THE MYOSITIS COMMUNITY

Name: _____

Date: _____

DOCTOR CERTIFICATION

This form, signed by your doctor, must accompany your application and supporting documentation.

I,_____(circle: patient / legal guardian / power of attorney)
(Print the patient's full name)

_____, DOB __ __/__ __/__ __ __ __, authorize the doctor and staff of
(Name of patient, if differs from above)

the facility or medical practice treating this patient to certify that said patient is currently receiving treatment for, or is in the process of being diagnosed with a type or subtype of idiopathic inflammatory myopathy (myositis), and is currently under their care.

Diagnosis: _____ DX code: _____

Doctor's Name (print) _____

Doctor's Signature _____Date _____

Doctor's Phone Number _____

Name of Hospital/Medical Facility _____

Street Address_____

City, State, Zip_____