DOCTORS STATEMENT OF
MEDICAL NEED FOR AIR CONDITIONING

DR. NAME: _____

ADDRESS: _____

PHONE: _____

PATIENT'S NAME: _____

I CERTIFY THAT THE ABOVE NAMED PATIENT HAS AN EXISTING LIFE THREATING CONDITION WHERE AN AIR CONDITIONER WILL ELIMINATE OR SIGNIFICANTLY REDUCE THE POSSIBLITY OF LOSS OF LIFE OR HEAT RELATED ILLNESS.

DOCTOR SIGNATURE: _____DATE: _____

NURSE PRACTITIONER: _____DATE:_____