AFFIDAVIT OF HEALTHCARE PROVIDER

(Healthcare Provider Only)

Part B. – Healthcare Provider

I, _____ certify that I am _____.
(Representative Name) (Position Title)

I certify that _____ is providing treatment for _____
(Healthcare Provider) (Patient)

at _____ from _____ to _____
(Location Outside of the District) (Date) (Date)

for a "serious health condition" as defined by D.C. Official Code § 32-541.01(20), and that I am authorized to provide this information on behalf of _____.
(Healthcare Provider)

I hereby certify all information submitted is true to the best of my knowledge.

Name of Representative (printed): _____
Position Title of Representative: _____
Email and Phone Number of Representative: _____
Email and Phone Number of Healthcare Provider: _____

_____
Signature of Representative

Subscribed and sworn before me, a Notary Public.

SEAL

Notary _____
Today's Date _____
Commission Expires _____