



HOPE419

Patient Name _____ Patient Date of Birth _____

I am requesting my treatment provider _____ to complete the following forms on my behalf. I accept the associated document completion fee associated below.

Form Requested:

_____ Medication Administration on school grounds/school trip: NO FEE

_____ Emotional Support Animal Letter for housing or travel: \$15

_____ Housing ESA Documentation requested by landlord: \$10

_____ FMLA Paperwork for self or caregiver: \$20

_____ College Housing or Academic Accommodations form: \$15

_____ Other documentation of illness form 1-2 pages (not including work excuse letter): \$10

_____ Other documentation of illness form 3 or more pages: \$20

_____ Other, please specify _____: not to exceed \$25

Purpose, if not clearly indicated by form: _____.

Date to be completed by _____.

Signature of Patient or Guardian _____.

Date _____