Patient Name:

Patient Birthdate:

Application Activity Description:

Exercise Grant CF Medical Provider Verification

Doctor's Name:

CF Clinic Name:

Center Mailing Address:

City/State/Zip:

CF Care Center Point of Contact:

Phone:

Email:

Dear CF Care Provider,
We have received an application from the applicant listed above for a Exercise Grant from BreatheStrong CF. Part of our application review process is to verify with their CF care provider for their current health status.

How long have you treated this patient?

How would you rate their compliance with medications and treatments on a scale from 1-10 (10 being 100% compliant)?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 10

Do you endorse their participation in the activity listed above as potentially beneficial to their health?

◯ Yes ◯ No

Do you have any concerns about their participation in the described activity? ◯ Yes ◯ No

As the primary CF provider for the patient listed above, I support and encourage their participation in physical activity as part of their well-being. I understand that BreatheStrong CF is not promoting any form of interaction between CF patients, and that the funds being applied for are strictly for individual purposes of promoting recreating as an additive measure of airway clearance. I feel that he/she is an excellent candidate to receive an exercise grant.

Signature:

Please return to the patient. The patient will upload this completed form with their application.