

# CALM

Phone: (416) 367-3459

Fax: (416) 367-4679

My patient, (legal name and DOB): \_\_\_\_\_.

Has been diagnosed with: \_\_\_\_\_.

Symptoms include: \_\_\_\_\_.

I understand that my office will be contacted via phone to verify this information.

Physician's Signature: \_\_\_\_\_.

Physician's Printed Name: \_\_\_\_\_.

Date signed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  
(Month) (Day) (Year)

Physician's Address:

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Applicants Contact Information:

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Notes:

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**Please keep a copy of this form at your doctor's office**  
*CALM reserves the right to refuse any member on a case by case basis*