

Name of Physician\_\_\_\_\_

Physician's Address\_\_\_\_\_

\_\_\_\_\_

Date\_\_\_\_\_

**PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY**

\_\_\_\_\_  
Applicant's Name

Control No.\_\_\_\_\_

\_\_\_\_\_  
Applicant's Address

I hereby authorize release  
of the requested information.

\_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

Dear Dr. \_\_\_\_\_:

The above named applicant is seeking state-aided housing with this Authority and has indicated that he/she is being displaced or has been displaced from his/her current housing because of a severe medical emergency.

In order to determine whether to grant priority status for this applicant, we must secure verification of a qualifying severe medical emergency. Therefore, we would appreciate your completing the verification on the reverse and returning this form directly to the Housing Authority. A representative of the Authority may contact you at a later date to confirm the information.

Sincerely,

\_\_\_\_\_  
*Executive Director or Tenant Selection Coordinator*

## PHYSICIAN'S VERIFICATION OF SEVERE MEDICAL EMERGENCY

1. Is the applicant or member of the applicant's household suffering from an illness or injury which poses a severe and medically documented threat to life or safety? (circle one)

YES

NO

NO OPINION

If YES, please explain: \_\_\_\_\_

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2. Is the applicant's current housing situation a cause of the illness or injury or is it a substantial impediment to treatment or recovery from this illness or injury? (circle one)

YES

NO

NO OPINION

If YES, please explain: \_\_\_\_\_

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3. How long has the applicant or household member been your patient? \_\_\_\_\_

4. For what are you currently treating the patient? \_\_\_\_\_

## PHYSICIAN'S CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

\_\_\_\_\_, MD  
Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Telephone: (\_\_\_\_)\_\_\_\_\_