Moment Nominee: _____

Medical Information:

Nominee Signature: _____

<u>This Part To Be Completed by Physician Only</u>

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

Fax Number: _____

Email: _____

Nominee's Diagnosis: _____

Current life expectancy in months: _____

I certify that I am the treating physician of the nominee. To the best of my knowledge, my patient has a life expectancy of _____ months or less. I certify that my patient is of sound mind and capable to sign legal documents. I have discussed (or will discuss) the Moment request with my patient and have deemed if safe and reasonable if his/her Moment is granted within the next _____ months.

_____	_____	_____
Signature of Physician, NP or PA only	Title	Date

Please email or Mail:

robin.fabulousmoments@gmail.com

Fabulous Moments
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