MEDICAL CERTIFICATION FORM

PLEASE HAVE THIS FORM COMPLETED BY THE DIAGNOSED INDIVIDUAL'S MEDICAL PROFESSIONAL. YOU WILL NEED A SIGNED MEDICAL CERTIFICATION FORM TO COMPLETE THE ONLINE APPLICATION.

ONCE THIS FORM IS FILLED OUT AND SIGNED BY THE DIAGNOSED INDIVIDUAL'S MEDICAL PROFESSIONAL, PLEASE COMPLETE THE APPLICATION AND UPLOAD THIS FORM WHERE INDICATED.

Medical Professional's Full Name:

Office Address:

City: State: Zip Code:

Office Phone Number: Office Email:

I certify and affirm that I am a licensed (check one):

- ☐ Medical Physician
- ☐ Physician's Assistant
- ☐ Nurse Practitioner

I further affirm that the person indicated below is one or more of the following: ASD, Autism, has an intellectual disability, or has a development disability as defined in Title 16, Chapter 55, captioned Persons Diagnosed with Intellectual Disabilities and Other Specific Developmental Disabilities, of the Delaware Code.

Patient's Full Legal Name:

Medical Professional's Signature: Date:

Medical Professional's Name (printed):

Medical Professional's License Number: State of Issuance: