

**CONNECTICUT GI
CHARITABLE
FOUNDATION**



**CONNECTICUT GI CHARITABLE FOUNDATION GRANT
PROOF OF DIAGNOSIS FORM**

This section to be completed by Grant Applicant

Applicant Name: _____

Health Care Provider Name: _____

Practice Name: _____

Street Address: _____

City: _____

State: _____ Postal Code: _____

Office telephone: _____

Health Care Provider E-mail (if applicable): _____

This section to be completed by Grant Applicant

I give permission for my clinician to complete this application for the purposes of a grant application:

Applicant Signature _____

This section to be completed by Health Care Provider

I certify that this applicant is under my medical care and has been diagnosed with:

- Crohn's disease
- Ulcerative colitis
- Liver disease. Please specify _____
- Other disease affecting the GI tract. Please specify _____

Provider Signature: _____ Date: ____/____/____

Credentials: _____

