



“Giving A Child Hope With A Second Wish”

Angela Small, President

Medical Eligibility Form

This form is used to determine Medical Eligibility

This Medical Eligibility Form must be completed and signed by an authorized health care professional who has direct knowledge of the Second Wish child’s medical condition and returned to the address below. Authorized health care professionals include licensed allopathic or osteopathic doctors of medicine, certified nurse practitioners and certified physician assistants. This form is being signed in connection with “A Second Wish” that may be granted by A Second Wish By Demetrius Inc. for:

Child’s Name (“patient”) _____ Patient’s date of birth _____

Patient’s qualifying condition _____

Parent(s)/ legal guardian(s): _____

Patient’s physician (“physician”): _____

Please indicate your eligibility determination by checking the appropriate box.

 PATIENT IS ELIGIBLE

I am familiar with patient’s physical condition and certify that at the time of referral the patient has been diagnosed with a life-threatening medical condition, defined as a progressive, degenerative or malignant medical condition that has placed the child’s life in jeopardy. By way of contrast, illnesses that are static or stable do not typically qualify.

 PATIENT IS NOT ELIGIBLE

I am familiar with patient’s physical condition and certify that the patient is not medically eligible at this time.

Authorized Health Care Professional’s Signature

Title

Authorized Health Care Professional’s Printed Name

Date

***This form must be sent directly from medical office and can be faxed to 1-800-626-0085. A letter will also be needed stating the Nominee is medically cleared for travel outside of home city.**