

CASE NO. _____

Affiant further certifies that he/she knows that the following treatment facilities are willing and able to provide the recommended treatment:

Name of Treatment Provider

Telephone Number of Treatment Provider

Name of Treatment Provider

Telephone Number of Treatment Provider

Name of Treatment Provider

Telephone Number of Treatment Provider

Physician's Signature

Name and Title of Physician (Please Print)

Telephone Number of Physician

License Number of Physician