



Medical Information Form

The Medical Information Form must be completed in its entirety.
This application must be received before the application can be processed and approved.
Mail the completed Medical Information Form to the address provided on the bottom of this form.

Wig Applicant or Parent/Guardian please complete this section

Applicant Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone (____)____ - _____ **Email Address** _____

WIG APPLICANT OR PARENT/GUARDIAN STOP HERE
THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A MEDICAL PROFESSIONAL

MEDICAL INFORMATION

Are you the Primary Medical Contact for the Wig Applicant? Yes No

Are you the Wig Applicant's Doctor Nurse Social Worker Other _____

Organization or Hospital Name _____

Physician's Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone (____)____ - _____ **Email Address** _____

By signing this Medical Information Form as a medical professional I hereby acknowledge and affirm
 This patient has a medical need for this prosthetic device; and
 This family would otherwise not be able to afford payment of this prosthetic device

Your Printed Name _____

Your Signature _____ **Date** ____/____/____

An official stamp or documentation (prescription, doctor's note, etc.) from a Medical Professional is required. Please affix in the space provided.

Official Medical Stamp

Please return this completed form to the Wig Applicant.

INSTRUCTIONS FOR THE WIG APPLICANT

Wig Applicant – Return all items on the checklist below to Wigs for Kids at the address listed below

Checklist

1. Medical Information Form
2. Medical Prescription that states cranial prosthesis and/or a referral letter from your practitioner
3. Proof of Age (**one** of the following are acceptable) – Birth Certificate, Passport, or State Issued ID
4. Current Picture showing areas of hair loss, and model picture for preferred wig style.

Wigs For Kids
ATTN: Recipient Department
24231 Center Ridge Road • Westlake, Ohio 44145