SPECIAL DELIVERY
SAN DIEGO

Doctor's Certificate

I _____authorize _____ to complete the
(Patient's Name) (Name of Clinic)
following form for Special Delivery San Diego.

_____
(Patient's Signature)

This is to certify that _____ is being treated at
(Patient's Name)

Clinic Address: _____

_____

Clinic Phone: _____

Physician's Diagnosis:

Please list patient's allergies to food:

Physician's assessment as to why this patient needs home delivered meals:

_____ _____ _____
(Doctor's Name) (Doctor's Signature) (Date)

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