**Please have your physician complete this form by Friday, May 10, 2019**

**and scan and email it to forms@hobyohiosouth.org.**

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Medication Verification Form for Physicians

**(Please type or print legibly)**

**(This form is to be completed by the participant’s prescribing physician. If the participant has more than one**

**prescribing physician, then each physician will need to complete a form. Please type or print legibly.)**

1. Name of Participant/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Prescribing Physician Name:
3. Prescribing Physician Medical License Number and State where licensed:
4. Please complete the chart below for the medications which you have prescribed to the participant.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Type of Medication | Condition for Treatment | Dosage | Frequency |
|  |  |  |  |  |
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|  |  |  |  |  |

1. Please affix physician’s business card or voided prescription in the space below.

As the prescribing physician, I attest that the use of the medications prescribed by me, and taken as directed as listed above, should not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

**⌦** **Signature of Prescribing Physician: Date:**