



SAMUEL MERRITT
UNIVERSITY

PHYSICIAN'S MEDICAL AUTHORIZATION

OCCUPATIONAL THERAPY CLINIC

(Please FAX to (510) 869-6951 and mail the original to the address below.
Thank you)

Patient's name:

Patient's Address:

Date:

Medical release for the above client to participate in: **Occupational
Therapy Evaluation and Treatments once a week for 10 weeks. (This
is a free clinic and the patient will not be charged)**

- Please describe any precautions that the above patient might have for the participation in therapy:

- Patient's primary diagnosis for therapy:

- Patient's secondary diagnosis:

Physician's Signature: _____ Date: _____

Physician's Name (Please print): _____