Kid Logistics - *Kid Busy Living!* **Adult** Program

Cystic Fibrosis Care Provider Authorization

Please have your Cystic Fibrosis care provider fill out this form. This form **MUST** be completed and included with your application to be considered for approval.

Applicant's Name: ___________________________________ Applicant's DOB: ______________________

Applicant's chosen activity: ____

CF Care Provider Information

Physician's Name:____

Name of CF Clinic:____

Clinic Mailing Address:____

City: __________________________________ State: __________ Zip: ___________________

Contact Person: ____________________________________ Position: ______________________________

Phone: ______________________________ E-mail: ____

To Be Completed by CF Care Provider

1. Do you verify that the applicant has been diagnosed with Cystic Fibrosis? **Yes/No**
2. Do you endorse the applicant's participation in the activity listed above as potentially beneficial to their physical and/or mental health? **Yes/No**
3. Do you have any concerns about their participation in these activities? **Yes/No**
   If so, please describe:

____

____

As the primary CF care provider for the patient listed above, I support and encourage their participation in the activity listed in this application.

_______________________________ ___________________________________ _____________

CF Physician (Signature) CF Physician (Print Name) Date