Place on Medical Provider’s Letterhead

Date:

State Council for Persons with Disabilities
Traumatic Brain Injury Fund
Attention: Dee L. Rivard, Program Manager
Margaret M. O’Neill Bldg., Suite 1
410 Federal Street
Dover, DE 19901

Dear TBI Application Review Committee Members:

As ______________________________________’s ____
Full Legal Name of Applicant/Patient PCP, PA, PT, OT, SLT, or other medical provider (MD or DO)

I am writing to certify that he/she has a traumatic brain injury resulting from ________________________
Mechanism of Injury

____ that occurred on: ____________________.
Mechanism of Injury (continued) Date of Injury (MM/DD/YY)

I believe that _______________________________________ would benefit from receiving the following,
Patient’s Name
service, treatment, therapy or equipment recommended below:

____
Requested service(s), treatment(s), therapy or equipment
____

____

Sincerely,

____
Signature
____
Name & Title of Treating Medical Provider

Acceptable Medical Providers Include: Applicant’s primary care physician (PCP) or other currently licensed medical professional in good standing, such as, but not limited to, MD, DO, Physician’s Assistant, Licensed Physical Therapist, Occupational Therapist, or Speech Language Therapist who is providing treatment for symptoms related to the applicant’s brain injury.

Please return this form to either of the confidential fax numbers below or by mail to the address at the top of this letter. Fax Numbers: 302-677-7066 or 302-739-1124