

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 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: _____
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, treatment, 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.