ALS Association Northern Ohio Chapter

Verification of Diagnosis

This document must be signed by a neurologist who is experienced in ALS.
Once this form is on file, you will not need to resubmit.
If you are not sure we have a verification of diagnosis form on file, please contact the Chapter office 216-592-2572/888-592-2572 or cathy@alsaohio.org.

To be completed by Patient or Caregiver:

Patient Name: ____

Address (P.O. Box will not be accepted) ____

City ____________________________________ State _________________ Zip ____________________

Home Phone ______________________________ Cell Phone ____

Date of Birth _____________________________ Email ____

Neurologist Name: _________________________ Telephone: ______________________________________

Address: __________________________________ City: _____________ State: ___________ Zip:_________

Hospital or Clinic: ____

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Must be signed by a Neurologist specializing in ALS or PLS:

By my signature, I verify that that the above named individual has a diagnosis of Amyotrophic Lateral Sclerosis (ALS) or Primary Lateral Sclerosis (PLS).

Select one: ALS PLS

____ (_____)_____________________

Physician Name (Please Print) Phone

____ _____________________________

Physician Signature Date

Completed form may be faxed to 216 592-2575 or emailed to cathy@alsaohio.org

************************** Office Use Only ******************************

Date received in ALS Office: __________________________