ALS Northern Ohio Chapter ASSOCIATION

** Date Received in ALS Office_____ **
*VOD on File _____ **

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 alscaregrant@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 _____

Spouse or POA:_____

Spouse/POA Phone _____ 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).

Circle one: ALS PLS

_____ (_____)_____
Physician Name (Please Print) Phone

_____ _____
Physician Signature Date

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