4. Medical practitioner's declaration

I certify that the information at sections 2 and 3 above is accurate, and that the above-mentioned treatment is medically appropriate.

Name: _____

Medical specialty: _____

Address: _____

Tel.:_____

Fax: _____

E-mail: _____

Signature of medical Practitioner:_____ Date : _____

5. Retroactive applications

Is this a retroactive application?	**Please indicate reason:**
Yes: □ **No:** □ If yes, on what date was treatment started? _____	Emergency treatment or treatment of an acute medical condition was necessary □ Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection □ Advance application not required under applicable rules □ Other □ Please explain: _____ _____ _____