

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: _____	