

**MEDICAL AUTHORIZATION**

WISH ADULT \_\_\_\_\_

**TO BE SIGNED AND DATED  
BY WISH RECIPIENT'S  
PRIMARY PHYSICIAN**

ADULT DIAGNOSIS \_\_\_\_\_



Memories of Love  
FOUNDATION  
4932 Sunbeam Road  
Jacksonville, FL 32257

COMPASSION PARTNERS  
210 SOUTH BASS ROAD  
KISSIMMEE, FL 34746

As the primary care physician for \_\_\_\_\_,  
(PLEASE PRINT WISH ADULT'S NAME)

I \_\_\_\_\_, M.D. am familiar with the physical condition of the above named adult and am of the opinion that the condition of the above named adult has a life-threatening and/or terminal illness. I have explained to the above named patient and/or spouse/guardian the medical condition of the above named patient. I have discussed with the patient and/or spouse/guardian the risks involved (both physically and mentally) by participation by the above named patient in fulfillment of the wish (as it was explained to me and hereinafter described). I have instructed them as to who to call in the event medical assistance is needed and how to handle medical emergencies.

**DESCRIPTION OF WISH**

Travel to Central Florida to spend up to six days/five nights at a Holiday Inn and visit theme parks: Disney Parks, Universal Studios / Islands of Adventures and SeaWorld.

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE  
*(Nurse or office staff cannot sign this form on behalf of doctor)*

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
PRINT PHYSICIAN'S NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN'S OFFICE ADDRESS

\_\_\_\_\_  
PHYSICIAN'S OFFICE PHONE

*Thank you for taking the time to complete this form for your patient.*

Doctor, is this your first introduction to Memories of Love? yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, how did you learn about us? \_\_\_\_\_ patient? \_\_\_\_\_ colleague?  
other?