The West Virginia Institute for Spirituality

M E D I C A L C E R T I F I C A T I O N

To the examining physician: Please supply the information requested in the 2 sections below.

Name of Patient: _____

Age _____ Height _____ Weight _____

1. **General Health:** Please indicate below any
   a) Significant impairment or disability (e.g., sight, hearing, etc.);
   b) Conditions requiring prescription medication or special dietary needs (e.g., diabetes, epilepsy, hypertension, etc.)
   c) Conditions requiring periodic supervision of a physician while here at the center.

   _____

   _____

   d) Allergies to drugs/medication. Specify _____

   e) If any mood-altering medications are now prescribed for this patient, please describe very briefly the effects of use.

   _____

   _____

2. **Treatment:**
   a) Hospitalization form for mental disorder? Yes/No _____ If yes, when and for what reason? _____
   b) Has patient received treatment for alcoholism? Yes/No _____ If yes, when?
   Dates: _____

Signed: _____ Date: _____
(Physician)

Telephone (_____)_____

Please mail to: (mark envelope "Confidential")
Sr. Carole Riley, CDP, Ph.D.

WVIS Executive Director
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