



Statement of Diagnosis

Name: _____

Address: _____

City: _____ Zip: _____

Date of Birth: _____

I certify that my patient, _____, has a documented diagnosis of HIV disease as follows (please check one):

HIV Asymptomatic _____

HIV Symptomatic _____

AIDS _____

Physician's Name _____

Signature _____

License Number _____ Phone (____) _____

Address _____ City _____ Zip _____

Date _____

Send to:

Project Chicken Soup
PO BOX 480241
Los Angeles, CA 90048