



STATEMENT OF DIAGNOSIS

Name: _____

Address: _____

City _____ Zip _____

Phone _____

Social Security Number # _____

Driver's License # _____

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 Code _____

Date _____

Please return to: Project Chicken Soup, PO BOX 480241, Los Angeles, CA 90048