



Canossian
Spirituality
Center

MEDICAL CERTIFICATION

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: _____
(Physician)

Date: _____

Telephone (_____) _____

Please mail or fax to:

Canossian Spirituality Center, 5625 Isleta Blvd. SW, Albuquerque, NM 87105 USA Fax: 505-877-2571