# IDISCY Foundation

**Purpose:** IDISCY Foundation is dedicated to providing equitable resources for individuals living with Muscular Dystrophy and related diseases to aid them in achieving their life goals.
**Eligibility Requirements:** Applicants must have been diagnosed with Muscular Dystrophy and/or other neuromuscular diseases. If you are unsure, please refer to the IDISCY Webpage for a comprehensive list.
***This form must be filled out in its entirety for the individual named below to be considered. This information will be used only for the IDISCY Foundation eligibility verification and will be treated with the utmost confidentiality.***

**RELEASE OF INFORMATION TO BE COMPLETED BY THE APPLICANT**

I, _____on _____
*(Printed name and signature of applicant)* *(Date)*

If applicant is under the age of 18:

_____on_____
*(Printed parent/guardian name & signature of parent/guardian)* *(Date)*

authorize _____
*(Printed name of physician)*

to release to IDISCY Foundation regarding my disease diagnosis to show I meet eligibility requirements for the IDISCY Diagnosis Verification.

**THIS SECTION TO BE COMPLETED BY LICENSED NURSE PRACTITIONER/PHYSICIAN**

I certify that _____ is under my medical care and has been

diagnosed with: _____.

If applying for medical equipment, I certify that _____ is

medically necessary because _____.

Physician's Telephone #: (_____)_____ Physician's Fax #: (_____)_____

Physician's Address: _____

_____
(Nurse Practitioner/Physician's Signature) *(Date)*