



PHYSICIAN AUTHORIZATION

Name of Participant:

First

Last

Participant Date of Birth

Name of Physician:

First

Last

Physician address:

Physician phone:

Physician email:

This certifies that the above Participant has become pregnant or has given birth since registering for the Sunday, June 9, 2024 event.

I hereby represent that I verified the details above with the Participant and I may be contacted for further verification.

Physician Signature

Physician Name (type or print)

Date

Steps to complete the accommodation request:

1) Download and print this PHYSICIAN AUTHORIZATION

3) Complete the PHYSICIAN AUTHORIZATION with physician's signature

4) Scan and return this form to office@chicago13point1.com by 11:59 p.m. (Central Time) on Wednesday, June 5, 2024