Medically Diagnosed for Autism Spectrum Disorder

PERSONAL INFORMATION

Name _____

Address _____

Phone number _____

PROVIDER INFORMATION

Date _____

My signature below verifies that this person has received a diagnosis of ASD by a licensed and/or certified professional.

Health Care provider signature _____

Specialty (e.g., M.D., Ph.D., Psy.D. etc) _____

License Number _____

EMERGENCY CONTACT INFORMATION

Name _____

Phone Number _____

Bring this completed form to any county health department along with a government issued identification card and $10.

Completed application forms will be maintained at the county health department in which they are filed. A government issued identification card must be presented to obtain a replacement certification card.

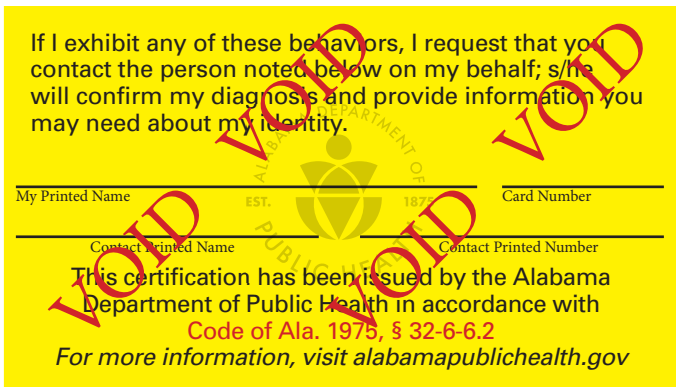
Fees.

(1) Initial Issuance. A fee of $10 shall be paid for initial issuance of a certification card.

(2) Replacement. A fee of $5 shall be paid to obtain a replacement certification card.

Below is an example of the Certification Card.

Front



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