MEDICAL PROVIDER VERIFICATION FORM

Covenant School Survivors Fund

Victim Name: _____ Date of Birth: _____

Provider Name: _____ Provider Phone: _____

Provider Address: _____ Contact Name at Provider: _____

Provider Fax #: _____ Provider Email: _____

National Provider Identifier (NPI): _____ (unique 10-digit identification number issued to healthcare providers)

Was the above individual your patient who you treated for physical injury resulting from the March 27, 2023 event at Covenant School? ☐ Yes ☐ No

First date you provided services to this patient for this injury: _____

Type of Provider (check one):

☐ Hospital/Medical Center

If Hosp/Med Center, was this inpatient care? ☐ Yes ☐ No

If inpatient, please provide the following:

_____ _____

Date of Admission Discharge Date

_____ _____

Name of Person Completing this Form Title of Person Completing this Form

☐ Outpatient Facility

☐ Medical Doctor/Surgeon

☐ Other (provide description): _____

_____ _____

Provider Signature Print Provider Name

_____ _____

Name & Title of Person Completing this Form if other than the Physician Date