



IF ONLY APPLICATION

Step 3 Statement of Eligibility

Applicant's Signature

Applicant's Name (Please print)

To Be Filled Out by Physician

Applicant's Diagnosis:

Prognosis:

___ Yes ___ No Under Hospice Care?

Physician's Name

Address

City/State/Zip

Phone Number with Area Code Fax
Number

Physician Signature

By signing the above, I certify that I am the treating physician of the individual named above. The applicant is of sound mental capability to sign legal documents. I have reviewed the request to be fulfilled by the "If Only" Program administered by the Department of Social Services and find that the applicant is physically able to participate in the activity requested.

Step 4 Publicity Release

Please follow the instructions carefully for any publicity release that may result in your approved application.

If your request is accepted, the "If Only" Program would like your permission to use your story and/or photo in one or more of the media listed below. We ask that you darken all circles that are acceptable to you. Giving us permission to share your story will help raise awareness and participation in the program.

The staff and volunteers with the "If Only" Program respect the privacy of individuals and will only use a recipient's first name if approval is given to use their story and/or photograph.

Please **darken the circle** for all means of publicity media that is acceptable to you:

- Local Newspaper, Radio, TV
- State and National Newspaper, Radio, TV
- Department of Social Services and Forsyth County Web Site devoted to the "If Only Program"
- All of the Above

Or

- Please do not use my story and/or photo in any of the above media.

