

**Fertility Foundation of Texas**  
3801 N. Capital Of Texas Highway, E-240, PMB#131  
Austin, Texas 78746  
**TEL** (888) 587-2406    **EMAIL** FertilityFoundationOfTexas@gmail.com

**GRANT APPLICATION: TREATING PHYSICIAN FORM**

I, \_\_\_\_\_, hereby confirm that I am the treating physician for \_\_\_\_\_ (patient's name) infertility care. I am submitting this form to the Fertility Foundation Of Texas per her/their request to establish that they have been evaluated by me and received a diagnosis and treatment plan. This patient's infertility diagnosis is: \_\_\_\_\_

\_\_\_\_\_.

The overall treatment plan I am recommending requires: \_\_\_\_\_

\_\_\_\_\_.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_