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: _____