

## "Head Covers Unlimited" Application Form

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(Must be filled out and signed by patient's attending physician.)

My patient:

\_\_\_\_\_

(Name)

who lives at

\_\_\_\_\_

(address)

\_\_\_\_\_

(city and state)

is eligible because of an acute medical condition or medical treatment for inclusion in the "Head Covers Unlimited" of Chickasaw County program sponsored by Mercy Medical Center - New Hampton Auxiliary.

\_\_\_\_\_

(attending physician)

\_\_\_\_\_

(by)

\_\_\_\_\_

(date)

Because of our belief in the dignity and value of each person, Mercy Medical Center - New Hampton affirms that each patient will receive accessible, respectful, skillful, and compassionate care without discrimination as to race, color, creed, gender, belief, national origin, age, disability or ability to pay.