**Section 100.APPENDIX B Medical Certification**

Please fill out this statement and return to the following address:

|  |  |  |
| --- | --- | --- |
| I certify that |  | suffers from a serious |
| health condition which can be ameliorated by cooling facilities. Illness or medical condition: |
|  |  |  |
|  | Asthma | [ ]  |
|  |  |  |
|  | Respiratory Allergies (requiring filtered air) | [ ]  |
|  |  |  |
|  | Severe obstructive lung disease | [ ]  |
|  |  |  |
|  | Severely debilitating stroke | [ ]  |
|  |  |  |
|  | Any medical condition of a non-ambulatory patient | [ ]  |
|  |  |  |
|  | Other – please specify: |  |
|  |  |
|  |  |  |
| Signature: |  |
|  |  |  |
| Name and Title/Degree: |  |
|  |  |  |
| Practice or Organization Name: |  |
|  |  |  |
| Registration No. |  |
|  |
|  |
| I hereby authorize this agency to verify that information provided by me and to contact my physician or other public health official for the purpose of securing medical certification as described above. |
|  |
| Name of Applicant |  | Signature of Applicant |  | Date |
|  |
| Social Security Number of Applicant |  |

(Source: Appendix B recodified from 89 Ill. Adm. Code 109.Appendix B at 33 Ill. Reg. 9466)