Therapy Equipment Prescription

(MUST BE COMPLETED BY THE PROVIDER)

Name of Child:____

Child's DOB:_________________

List the therapy grant equipment being prescribed:

Provider Name:_______________________________________ Provider Clinic:____________________

Medical/Therapy credentials: ____

Provider Phone: ___________________________________ Provider Fax: ______________________

Provider Email: ____

What is the duration that you believe the equipment will be required?

Provider Signature: ____ Date: ________________________

Please return to:
The ISAAC Foundation
28 W. Third, Ste. B-1
Spokane, WA 99201