BLU MATTER
PROJECT

Applicants: Please print this page, have your doctor fill out and sign it, and send a copy to info@blumatterproject.com.

I, _____ [name], am the referring physician of _____[applicant name.]

I confirm that _____[applicant name] has been diagnosed with _____[diagnosis] and is under my care on an ongoing basis. I understand the requirements of the Blu Matter Project program and am available and willing to track the progress of _____ [applicant name] and provide support when necessary as they move through the program.

Legal Name of Practice/Clinic: _____
Address/Location of Practice/Clinic: _____
Phone number: _____
Email: _____
Doctor's Signature: _____

Doctors: Please note that a Blu Matter Project Administrator will be in contact with you or your clinic to verify the information you have included here.