PORT MALABAR HOLIDAY PARK
MOBILE HOME PARK RECREATION DISTRICT
215 Holiday Park Boulevard NE
Palm Bay, Florida 32907-2196

CAREGIVER AUTHORIZATION

To be completed by our resident who is the patient:

Name: _____ HP Address: _____

We understand you are recommending the service of a Caregiver for the person named above.

This person resides in Holiday Park, a 55+ Senior Community Deed Restricted community, there are Rules & Regulations that require the district to be notified by the physician when a Caregiver is required to accommodate our resident, we're requesting you provide the following information:

_____(Name of Patient), requires medical care at home as indicated (Please check one)

____ As prescribed/when needed OR ____ 24 hours per day

Requiring which type/level of medical care at home as indicated (Please check one):

____ Certified RN, LPN, CMA or CN OR ____ Other

Name of Authorized company/person(s) _____

Phone # of Authorized company/person(s) _____

Name of Authorized company/person(s) _____

Phone # of Authorized company/person(s) _____

Authorization beyond the time indicated (maximum of 6 months) will require the patient to obtain additional verification. It is the responsibility of the patient or family member to obtain the approved extension. By signing this document, you as the Doctor authorize Caregiver services for your patient.

_____ _____ _____

Physician Signature Telephone Number Date

_____

Florida License Number

Physician's Stamp