Form 3

Medical/Mental Health Professional Form

Patient (Tenant) Name _____

1) **I am a licensed medical/mental health professional treating the above named individual's mental or emotional disability.**

   Initial to Confirm _____

2) **I certify that the above named individual has a mental health related disability listed in the Diagnostic and Statistical Manual of Mental Health Disorders and is under my care.**

   Initial to Confirm _____

Medical/Mental Health Professional's License Information

License Number: **Date License Issued:** **State Where issued:**

_____ _____ _____

Name of Practice: **Phone:**

_____ _____

Name (Printed) _____

Signature: _____ Dtd. _____