Physician Certification Form -- Dream Flyer Program

Date: _____

Name of Dream Flyer Applicant: _____

I, _____, am the treating physician for the above-named Dream Flyer Applicant. I certify that the Applicant is seriously ill or disabled, and suffers from the following condition(s):

_____

_____

I also certify that the Dream Flyer Applicant is able to participate safely in a Dream Flight, as described at abovethecloudskids.org.

The following accommodations would be necessary on Flight Day:

_____

_____

Signature, Treating Physician _____

Printed Name _____ Title _____

Address_____

_____

_____

Phone _____Email _____

Please Email this form to info@abovethecloudkids.org, or mail it to Above the Clouds at the below address.

Thank You.

Above the Clouds
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125 Access Road
Norwood, Massachusetts 02062
617-840-1710