Georgia Firefighters Burn Foundation
John, Lynne and Nicole Belli Memorial Endowment
Verification of Burn Injury Form

Patient First Name | Patient Middle Name | Patient Last Name

Date of Birth (Month/Day/Year)

Name of Hospital Where Treatment Received

Name of Attending Physician

Date of Admission | Discharge Date

I certify that I am an authorized representative/employee of the above named medical institution and confirm that the patient information above is true and accurate to the best of my knowledge.

Authorized Medical Professional Printed Name

Authorized Medical Professional Signature | Date

Job Title/Position

Street Address

City | State | Zip Code

Telephone | Alternate Telephone

Email