National MPS Society
Support for Families. Research for a Cure.

Medical Travel Assistance Program

Step 2—Verification Form

To be completed by Medical Professional: Please Print Legibly

Name of Individual with MPS or ML _____

Diagnosis_____ Date of Birth _____

Appointment date/time_____ Medical Facility _____

Medical Facility Address, State, Zip _____

Medical Professional _____ Specialty _____

This is to verify an onsite visit by the above listed patient for the following medical reason(s):_____

_____

_____

_____

_____

Medical Professional Signature

_____

Date