



Medical Statement Addendum

To be completed on all applicants and household members

Name: _____

Date of Birth: _____

Please complete the following questions for all medications currently being taken:

Medication: _____

Dosage/Frequency: _____

Reason for Med: _____

Prescribing Doctor: _____

Medication: _____

Dosage/Frequency: _____

Reason for Med: _____

Prescribing Doctor: _____

Medication: _____

Dosage/Frequency: _____

Reason for Med: _____

Prescribing Doctor: _____

Medication: _____

Dosage/Frequency: _____

Reason for Med: _____

Prescribing Doctor: _____

Please complete the following questions regarding any non-routine medical treatment or any mental health and/or drug and alcohol treatment you have received in the past 5 years.

Reason for treatment: _____

Diagnosis: _____

Outcome/ongoing treatment: _____

Treating doctor/therapist: _____

Reason for treatment: _____

Diagnosis: _____

Outcome/ongoing treatment: _____

Treating doctor/therapist: _____

Reason for treatment: _____

Diagnosis: _____

Outcome/ongoing treatment: _____

Treating doctor/therapist: _____

Reason for treatment: _____

Diagnosis: _____

Outcome/ongoing treatment: _____

Treating doctor/therapist: _____

I hereby affirm that I have completed this form to the best of my ability and that the information provided is true and correct.

Signature of Applicant, Adult Household Member, Parent, or Guardian

Date