UofL Health Care
University Hospital

PATIENT NAME:_____

PATIENT ACCOUNT NUMBER:_____

To Whom It May Concern:

I, _____, do hereby state that _____ (patient)

Is not working, has no benefits of any kind and is receiving no money from any source.

Signed: _____

Address: _____

_____

Date: _____

Please Note:

This form must be signed by a notary public

Notary Public:_____

My commission expires:_____