Paralyzed Veterans of America
Wisconsin Chapter

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Associate Membership Physician's Statement

To be filled out and signed by the physician
(Effective 8/25/2026)

Applicant name (printed): _____

I attest that the above-named individual is currently under my care for and has been diagnosed with one of the conditions listed below (check all that apply):

- ☐ Progressive neurological diseases
- ☐ Progressive neuromuscular diseases
- ☐ Limb amputations (full or partial)
- ☐ Significant, debilitating, mobility-limiting orthopedic condition
- ☐ Other permanent medical conditions producing impairments comparable to those experienced by individuals living with spinal cord injury, disease/dysfunction, amyotrophic lateral sclerosis, or multiple sclerosis

Name of the condition(s):_____

_____

The above listed individual requires the following:

- ☐ Prosthesis
- ☐ Wheelchair/Powerchair
- ☐ Scooter
- ☐ Walker
- ☐ Cane
- ☐ Other (please list): _____
- ☐ Does not require a mobility assistance device

Physician's Name (MD, DO, NP, PA): _____

Physician's Title: _____

Physician's Phone/E-mail: _____

Physician's Signature: _____

Date Signed: _____