



Tree of Life Grant
In Partnership with Fertility Foundation of Texas

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Austin, Texas 78746

TreeofLifeGrant.com

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Please note "Tree of Life Grant" in the subject line

GRANT APPLICATION: TREATING PHYSICIAN FORM

I, _____, hereby confirm that I am the treating physician for _____ (patient's name) infertility care.

I am submitting this form to the Fertility Foundation of Texas per her/their request to establish that they have been evaluated by me and received a diagnosis and treatment plan. This patient's infertility diagnosis is: _____

The overall treatment plan I am recommending requires:

Signature: _____ Date: _____

Printed Name: _____