

**STATEMENT OF ATTENDING PHYSICIAN
FOR DEPENDENT RELATIVES**

File No. _____

To assist in meeting the requirements of the Zoning Code of Spokane County concerning a licensed physician's statement regarding the nature of the medical problem, I submit the following information.

1. Full name and address of person(s) for which information is given below:

2. The Zoning Code of Spokane County defines a "dependent" person as a person who has been determined by a licensed physician to be physically or mentally incapable of caring for themselves and/or their property. Do you believe your patient is so qualified at the present time?

Yes No

3. Describe the nature of the medical or health-related circumstance(s), physical and/or medical, which established a "dependency" situation:

4. Is this circumstance of short or long term duration?

Short term Long term

Physician's Name, ***Please Print***

Physician's Signature

Date

Business Address

Phone