T: 888-648-6228 E: mwff@mitoaction.org

Letter to the Physician

To be completed by Applicant:

Applicant's Name (First, Middle, Last)	Street Address
Date of Birth	City/State/Zip
Telephone	Email Address

Description of the service, equipment or assistance for which this grant is being applied:

_____

_____

_____

Signed: _____ Date: _____
(Applicant/Parent/Guardian)

.....

Dear _____,
(Name of Provider)

Your patient is applying for assistance from the Marcel's Way COVID-19 Relief Fund of MitoAction. Please provide a statement on letterhead verifying your patient's diagnosis of a mitochondrial disorder and also describing how the service/equipment/assistance described above relates to his or her condition. Please include any information about the patient's situation that may be pertinent for the review committee to consider.

Please attached this cover letter with your letter of explanation and diagnosis verification and return to MitoAction by email at mwff@mitoaction.org or regular mail at P.O. Box 310, Novi, MI 48376.

All communications will be kept confidential. We will acknowledge receipt of your submission to the Applicant, on your behalf. If you have any questions, please do not hesitate to contact MitoAction.

Thank you for your time!