COVID-19 POSITIVE PHYSICIAN AUTHORIZATION

Name of Participant: _____ _____
First Last

Participant Date of Birth _____

Name of Physician: _____ _____
First Last

Physician address: _____

_____

_____

Physician phone: _____

Physician email: _____

This certifies that the above Participant received a positive COVID-19 test result per the details below:

COVID-19 Test Type: _____

Entity issuing the result: _____
(e.g. healthcare entity, laboratory, manufacturer)

Specimen collection date: _____

I hereby represent that I verified the details above with the Participant and I may be contacted for further verification.

_____ _____ _____
Physician Signature Physician Name (type or print) Date

Steps to complete the accommodation request:
1) Complete the intake form on the website
2) Download and print this COVID-19 POSITIVE PHYSICIAN AUTHORIZATION
3) Complete the COVID-19 POSITIVE PHYSICIAN AUTHORIZATION with physician's signature
4) Scan and return this form to office@chicagomarathon.com by 11:59 p.m. (Central Time) on Sunday, October 10, 2021