



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 has become pregnant or has given birth since registering for the Sunday, June 6, 2027 event.

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) Download and print this PHYSICIAN AUTHORIZATION

3) Complete the PHYSICIAN AUTHORIZATION with physician's signature

4) Scan and return this form to office@chicago13point1.com by 11:59 p.m. (Central Time) on Wednesday, June 2, 2027