



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@chicago5k.com by 11:59 p.m. (Central Time) on Saturday, October 9, 2021