RISE Bursary Program
Physician Confirmation of Condition

To be completed by a healthcare professional:
I confirm that the applicant has been diagnosed with cholestatic liver disease or is the sibling of an individual with this diagnosis who is under my care. Do **not** include diagnosis details beyond the confirmation of eligibility. This confirmation will be used solely to verify eligibility and will not be shared outside the RISE Bursary Program administration.

Applicant name: ______________________________

Physician name: ______________________________

Credentials: ______________________________

Address: ______________________________

City: ____________ Province: ____________ Postal code: ____________

Email: ____________________ Phone: ____________________

Signature: ____________________ Date: ____________________

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