

Health Affidavit

Patient Name	Age	Years Living in Union	Occupation	Telephone

Address: _____

Pre-existing medical conditions (list):

Medical conditions after ARWF* (list):

Medications prior to ARWF*:

Medications after ARWF*:

Physician information:

Name: _____

Address: _____

Telephone: _____

Physicians signature:

Date: _____

*Antelope Ridge Wind Facility