GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

ADDING A NEW DEBILITATING MEDICAL CONDITION

Name of Person/Entity Requesting:	**Entity's Name of Point of Contact:**
Mailing Address	**Email Address**
Telephone Number	**Medical Condition being added:**

Description of Symptoms

_____

_____

_____

_____

Availability of Conventional Medical Treatment

_____

_____

_____

_____

Summary of Evidence

_____

_____

_____

_____

Published Articles or Journals

_____

_____

_____

_____

_____
SIGNATURE OF REQUESTOR/DATE