

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFFIDAVIT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), certify that during the following period of time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (beginning date) to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (ending date) I was without income or resources with the exception of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dollar amount) from the following source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I make this certification in application for any financial assistance to which I might be entitled on account of my financial position. I understand that should this certification prove to be false in any material aspect, OHSU may reverse any financial assistance granted and hold me personally responsible for the charges.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(signature) (date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print name)