

# 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