WONDERFOLD®

SPECIAL NEEDS Discount Application

This form MUST be completed by the patient's medical care provider.
(Physician, Physical Therapist, Medical Social Worker, or Child Life Specialist)

Provider Name _____ Provider Title _____

License Number (Not NPI#) _____ State Provider is Licensed in _____

Hospital or Medical Institution Name _____

Patient's Medical Diagnosis _____

Please describe how our stroller wagons will benefit the patient emotionally, physically, psychologically, and/or socially _____

_____

_____

_____

Will our stroller wagon products be a part of the patient's medical treatment plan? Yes / No

_____ _____

Legal Guardian's Signature (Required) Date

_____ _____

Medical Care Provider Signature (Required) Date