

To Whom It May Concern

Patient's name: _____

The person listed above has hemophilia, a bleeding disorder, and is one of my patients.

During their travels they require the drug (product name) _____, a clotting factor concentrate, syringe, and needles for self-infusion to treat and/or prevent bleeding. Please allow the patient to carry these essential medicines & supplies on their person.

Thank you for your support and understanding.

Date ____ / ____ / ____

Doctor's Name: _____

Doctor's Signature: _____

Institution: _____