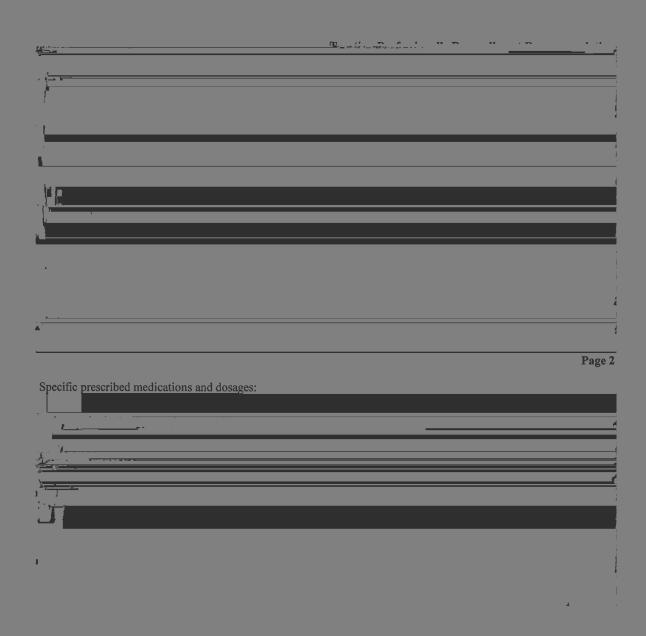


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Physician or Mental Health Professional's Assessment and Recommendation Regarding Patient's Readiness for Reenrollment

(please write very legibly)				
Date:				
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Physicia	n or Mental Health Professio	onal Providing This Report:		
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Nomoon	d Degree:			
Name an	d Degree.			
	_MD (primary care provider)	MD (psychiatrist)	Psychologist,	
	Social Worker	Counselor	Other:	
Business Address:				
Phone:				
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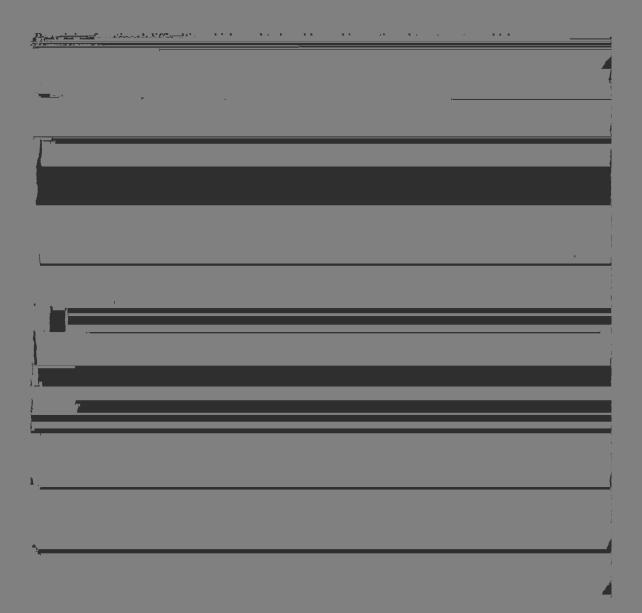
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Treating Professional's Reenrollment Recommendation
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