Recipient Application and Medical Verification

Name (First, Middle Initial, Last): _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Email: _____

Terms and Conditions:

Exotic Hair Cares reserves the right to provide Recipients with only one (1) customizable wig within a 3 year period. It is the Recipient's responsibility to maintain the quality of the customized wig. The Hair Doctor may provide additional services as needed or requested by the Recipient at his or her sole financial responsibility.

I have read, understand, and agree to the terms of this application:

- The Recipient must be 18 years or older to apply for a customizable wig.
- At the time of the Recipient's initial wig consultation, he or she will provide a Government issued photo I.D.
- At the time of the Recipient's initial wig consultation, he or she will be required to have a "before" photo taken by the stylist performing the consultation.
- The Recipient will provide the stylist performing the initial wig consultation a photo of his or herself showing the style of wig that he or she will like the stylist to achieve.
- This recipient application and medical verification must be directly emailed to Exotic Hair Cares, at hello@exotichaircares.com

Signature: _____

Date: _____

Medical Verification

Clinic/Hospital: _____

Physician: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Email: _____

Please Check Only The Boxes That Apply To The State of Your Medical Condition:

- ☐ I will be suffering hair loss due to cancer
- ☐ I will be suffering hair loss due to alopecia
- ☐ I have suffered hair loss due to cancer
- ☐ I have suffered hair loss due to alopecia

This referral covers the application process for one (1) customizable wig free of charge to be provided through The Hair Doctor.

Physician Signature: _____

NPI #: _____
