



Triad Adult & Pediatric Medicine

Focused on Excellence, Devoted to Care

Letter of Support

To whom it may concern:

I _____ state that:
(Print name of person who provides support)

I provide support for _____ (Name of Enrollee)

Signature: _____ Date: _____

North Carolina County Of _____

_____, appeared before me the undersigned notary being duly sworn, says that the information provided in this document is true as written to the best of my knowledge.

Notary Signature

Printed Name

My commission expires on: _____

(Seal)

Providing comprehensive
healthcare with compassion &
respect to our community.