Physician's Statement of Treatment

Patient Name ____

Patient DOB ____________________ **SS#** ________________________

I, _____________________________, am currently seeking financial assistance
(Print Beneficiary Name)
from Cancer Alliance of Help and Hope, Inc. ("CAHH"). One of the requirements for assistance is that my physician(s) provide verification that I am a cancer patient currently in **active treatment** or I have been treated within the last 4 months. Please read and complete the bottom portion of this letter and send it directly to the Cancer Alliance of Help & Hope office by mail or email.

Patient Signature _______________________________ **Date** _______________

Physician

I, ____, am currently treating
(Print Full Name of Doctor)
_______________________ and acknowledge that he/she is currently receiving
(Print Name of Beneficiary)

(Please check all treatments that apply)

___ Infusion Chemotherapy / drug name __________________________________
___ Oral Chemotherapy / drug name _____________________________________
___ Radiation Treatment

Date of last treatment ___________________
If treatment has been completed, what was the last date of treatment? ____________

Physician Signature _____________________________ **Date** __________

Physician Name (Print) ______________________________________

Treatment Facility____

Address ____

City, ST, Zip ____

Phone # ____

P.O. Box 3292, Palm Beach, FL 33480
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Email: canceralliance@gmail.com