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PINK WARRIOR Angels

Medical History Verification Form

Applicant Name: _____Date of Birth: _____

To Be Completed by Physician / Nurse Practitioner:

I, _____, verify that _____,
(Practitioner Name) (Applicant's Name)

Was/is under the care of_____,at_____,
(Primary Practitioner) (Institution)
from the dates of _____ to _____
for a diagnosis of _____

Protocol: e.g., last day of chemo/radiation

(Start of Protocol)_____ (End of Protocol)_____

Please check which ONE of the following criteria is met by this patient:

____Completed planned treatment with no evidence of disease

____In remission and on long-term hormonal therapy or long-term targeted therapy (please specify): _____

____ Currently undergoing treatment for a cancer diagnosis

____ None of these answers apply: explain_____

By signing this form, I hereby confirm to Pink Warrior Angels of TX that the information provided above is accurate to the best of my knowledge and that the individual applying for financial assistance from Pink Warrior Angels of TX has, at this time, completed treatment or is currently receiving treatment for an oncologic/hematologic disease.

Physician/Practitioner Signature:_____Date: _____

License Number of Above MentionedPhysician/Practitioner:_____

Patient records are not necessary at this time