Financial Assistance Program – Patient Treatment Verification Form

The Patient Treatment Verification Form must be completed by the physician or the office of the physician. Please submit the form to Foundation@FLCancer.com or fax to (813) 623-4703.

Forms will not be accepted if completed by the applicant or a friend/family member of the applicant.

Patient Information:

First Name: _____ Last Name: _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

Physician/Oncologist Information:

First Name: _____ Last Name: _____

Patient Treatment Information:

Name of treatment institute: _____

Address of treatment institute: _____

Phone number of treatment institute: _____

Is the patient named above currently under active cancer treatment?

- ☐ Yes
- ☐ No

What is the patient's cancer diagnosis? _____

What type of treatment is the patient receiving? Check all that apply.

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Immunotherapy
- ☐ Hormone therapy
- ☐ Hematopoietic progenitor cell transplantation
- ☐ Other(s): _____

Treatment Start Date: _____ Treatment End Date: _____

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____