FLORIDA CANCER SPECIALISTS Foundation

Patient Treatment Verification Form

This form must be completed and signed by a licensed physician/oncologist or licensed PA/NP within 30 days of the application submission date.

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Phone Number: _____

The section below must be completed by your physician or a licensed PA/NP.

Physician First Name: _____ Physician 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 code? _____

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

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Immunotherapy
- ☐ Hormone therapy
- ☐ Hematopoietic progenitor cell transplantation

If treatment is ongoing **with** no defined end date, a reevaluation date is required.

Treatment Start Date:_____ Treatment End Date: _____

Physician Signature: _____ Date: _____