Medical History Verification Form

L.I.F.E.
www.givetolife.org

Form must be completed by a Licensed Practitioner

***Applicant First Name**: _____ ***Applicant DOB**: _____

***Applicant Last Name**: _____ ***Applicant Age**: _____

Part A - Attestation:

I, _____,_____, verify that _____
***(Practitioner Name)** ***(Credentials)** ***(Applicant Name)**

was diagnosed with _____ on _____.
***(Most recent cancer diagnosis)** ***(Date of diagnosis)**

They were under the care of _____ , at _____.
***(Oncologist Name)** ***(Institution)**

Part B - Remission Status or Current Response (*check one of the following):

*This grant application is for young adult cancer survivors aged 18 - 30. Visit our **website** for detailed eligibility.*

☐ **Complete Response/Remission** ☐ **Stable Disease**

☐ **Partial Response/Remission** ☐ **Active/Progressive Disease**

Part C - Treatment

☐ Treatment ended on the following date: _____ OR

☐ Treatment is current/ongoing (select one of the following):

- ☐ On long-term hormonal therapy taking the following medication(s): _____
- ☐ On long-term targeted therapy taking the following medication(s): _____
- ☐ On immunotherapy taking the following medication(s): _____
- ☐ Patient is receiving treatment for active disease (please provide additional information): _____

_____

By signing this form, I confirm that the information provided above is accurate to the best of my knowledge, and the individual applying for this grant has, at this time, completed treatment for an oncologic/hematologic disease.

*Practitioner Signature: _____ *Date: _____

*National Provider Identifier (NPI): _____

Please return this form to the applicant once all sections have been completed.