Medical History Verification Form

Expect Miracles FOUNDATION

Applicant Information (to be filled out by a applicant)

Full Name: _____ Date of Birth: _____

Email: _____ Phone Number: _____

Practitioner Information (to be filled out by a practitioner)

Part A:

I, _____ , verify that _____, was diagnosed with
(Practitioner Name) (Applicant Name)

_____ on _____.They were under the care of
(Most recent cancer diagnosis) (Date of diagnosis)

_____, at _____ , from _____ to:
(Oncologist Name) (Institution) (Start of Protocol Date)

- ◯ End of Protocol (i.e., last day of chemo/radiation) _____ **OR**
- ◯ Current/ongoing (please explain): _____

Part B:

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

- ◯ Completed planned treatment with no evidence of disease
- ◯ One year following the completion of planned treatment with stable disease
- ◯ In remission and on long-term hormonal therapy, or in remission and on long-term targeted therapy, or in remission and on immunotherapy (list medication(s)): _____
- ◯ This patient does not meet any of these criteria

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

Practitioner Signature: _____ Date: _____

National Provider Identifier (NPI): _____