Medical History Verification Form

Expect Miracles FOUNDATION

Applicant Information (to be filled out by applicant)

Full Name: _____ Date of Birth: _____

Email: _____ Phone Number: _____

Practitioner Information (to be filled out by a practitioner)

Eligibility: This grant application is for young adult cancer survivors aged 21-39. All radiation and chemotherapy (including oral chemo) must be completed to be eligible.

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 _____, beginning on _____
(Oncologist Name) (Institution) (Start of Protocol Date)

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

- ☐ Complete Response/Remission
- ☐ Partial Response/Remission
- ☐ Stable Disease
- ☐ Active or Progressive Disease (patient is ineligible at this time)

Part C - End of Treatment Protocol:

- ☐ Protocol 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 any 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.