Medical History Verification Form

Expect Miracles FOUNDATION

Form Must Be Fully Completed by a Licensed 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.*

Applicant First Name: _____ Applicant DOB: _____

Applicant Last Name: _____ Applicant Age: _____

Part A - Attestation:

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

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

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

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:

- ◯ 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 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.