PHYSICIAN VERIFICATION FORM

Applicant's Name: _____

Applicant's Signature: _____

The above-named applicant has applied for a grant from Marisa's Mission, Inc., a 501(c)(3) non-profit organization dedicated to making a difference in the lives of cancer patients and their families. The application requires verification of the applicant's medical condition from a treating physician. Your assistance is greatly appreciated.

Physician's Name: _____

Physician's Address: _____

_____

Applicant's Diagnosis: _____

Date of Diagnosis: _____

Current Treatment Plan (please indicate if terminal diagnosis): _____

_____

I certify that the above-named patient named has been diagnosed with cancer, is under my care for the treatment of such cancer and it is anticipated that she/he will undergo the treatment plan described above.

Physician Signature _____

Date: _____