

## Physician's Statement of Treatment

**Patient Name** \_\_\_\_\_  
**Patient DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_

I, \_\_\_\_\_, am currently seeking financial assistance  
(Print Beneficiary Name)  
from the Cancer Alliance of Naples, Inc. ("CAN"). One of the requirements for assistance is that my physician(s) provide verification that I am a cancer patient currently in treatment. To that end, please read and complete the bottom portion of this letter and send it directly to the CAN office by mail and/or facsimile.

**Date** \_\_\_\_\_ **Patient Signature** \_\_\_\_\_

I, \_\_\_\_\_, am currently treating  
(Print Full Name of Doctor)  
\_\_\_\_\_ and acknowledge that he/she is currently affected  
(Print Name of Beneficiary)  
from cancer.

**Date** \_\_\_\_\_ **Physician Signature** \_\_\_\_\_

**Physician Name (Print)** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City, ST, Zip** \_\_\_\_\_  
**Phone #** \_\_\_\_\_

**Cancer Alliance of Naples, Inc.**  
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