



Physician's Statement of Treatment

Patient Name _____

Patient DOB _____ SS# _____ Phone _____

I, _____, am currently seeking financial assistance from
(Print Beneficiary/Patient Name)

the Cancer Alliance of Naples, Inc. ("CAN"). One of the requirements for assistance is that 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. *CAN provides financial assistance for qualified patients only while they are in active treatment.*

Date _____ Patient Signature _____

.....

I, _____, am currently treating
(Print Full Name of Doctor)

_____ and acknowledge that he/she is
(Print Name of Beneficiary/Patient)

is currently being treated for cancer. The type of cancer is _____, Stage _____

The date of the diagnosis is: _____

Start date of Tx. _____ Targeted date of Tx. Completed _____

of Chemotherapy Sessions _____ # of Radiation Sessions _____

Date _____ Physician's Signature _____

Physician's Name (Please print) _____

Address _____

City _____ ST _____ ZIP _____

Phone # _____ Fax # _____

Cancer Alliance of Naples
733 Fourth Avenue North , 2nd floor
Naples, FL 34102
Phone: 239/436-HOPE (4673)
www.cancerallianceofnaples.com

PLEASE COMPLETE FORM & Fax to: 239/436-5476