# Physician's Statement of Treatment

Cancer Alliance of Naples | Serving Collier & Lee Counties

Patient Name_____

Patient DOB _____ SS# _____ Ph#_____

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 _____

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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 _____

This patient is no longer in treatment and is now under the care of _____ Hospice.

Date_____ Physician's Signature_____

Physician's Name (Please print) _____
Address_____
City _____ST_____ZIP_____
Phone #_____ Fax #_____

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