APPLICATION FOR CANCER GRANT

MAIL COMPLETED APPLICATION TO: LADIES AUXILIARY VFW POST 392, 2408 BOWLAND PKWY, VIRGINIA BEACH, VA 23454-5207

Auxiliary No._____Member's Full Name_____

Street Address_____

City_____State_____Zip Code_____

Home Phone No.(____)_____Work Phone No.(_____)_____

Member's Signature_____Date Signed_____

IF PATIENT IS UNAWARE OF CONDITION

In all cases where the patient is unaware, the check will be made payable to the member and mailed to the person shown below as the Next of Kin, or Person holding Power of Attorney.

Name_____Phone No.(_____)_____

Address_____City_____State_____Zip Code_____

This part to be filled out by the Attending Physician.

1. Type of cancer diagnosed?_____
2. Was condition pathologically diagnosed as cancer? Yes or No Date_____
3. Was patient hospitalized for **this** cancer condition? Yes or No From_____To_____
4. Did patient have surgery for cancer? Yes or No Type of surgery:_____

5. Will the patient receive treatment for the above cancer diagnosis? Yes or No
6. If so, what type of treatment? (Specify)_____
7. First date of treatment for **this** cancer:_____

Attention Doctor:Thank you very much for your cooperation in furnishing information pertaining to the diagnosis and treatment of cancer for our Auxiliary Member.

Physician's Signature:_____Phone No.( )_____

Physician's Name (printed):_____Date:_____

Address:_____City:_____State_____Zip Code_____