EXPECT MIRACLES FOUNDATION + the samfund

Medical History Verification Form *(Fall 2021 Family Building)*

Applicant: Please complete Part A, then forward this form to a licensed medical professional.

Part A.

Applicant Name: _____ Date of Birth: _____

Applicant Email: _____ Applicant Phone: _____

Part B.

Provider: The abovementioned individual is applying for a Samfund grant. Please complete Parts B and C, below. *When these sections are completed,* ***the form should be returned to the applicant as soon as possible.*** *To ensure that your applicant can complete their application, please do not return this form to Expect Miracles Foundation.*

I, _____, verify that _____, was diagnosed with
(Practitioner Name) (Applicant Name)

_____ on _____. They were under the care of
(Diagnosis) (Date of Diagnosis)

_____, at _____, from the
(Primary Practitioner) (Institution)

dates of _____ to _____. .
(Start of Protocol) (End of Protocol)
e.g., last day of chemo/radiation
Please do not write "ongoing" or "current" without explanation

Part C.

Please check which **ONE** of the following criteria is met by this patient:

____Completed planned treatment with no evidence of disease

____One year following the completion of planned treatment with stable disease

____In remission and on long-term hormonal therapy, or in remission and on long-term targeted therapy (please specify): _____

____This patient does not meet any of these criteria

By signing this form, I confirm that the information provided above is accurate to the best of my knowledge, and that the individual applying for a grant from Expect Miracles Foundation has, at this time, completed treatment for an oncologic/hematologic disease.

Physician/Practitioner Signature: _____ Date: _____

License Number of Above Mentioned Physician/Practitioner: _____

Please DO NOT attach the patient's medical records.