



Physician's Statement of Treatment

Patient Name _____

Patient DOB _____ SS# _____

I, _____, am currently seeking financial assistance
(Print Beneficiary Name)
from the Cancer Alliance of Help and Hope, Inc. ("CAHH"). One of the requirements for assistance is that my physician(s) provide verification that I am a cancer patient currently in treatment, or have been treated within the last 4 months. Please read and complete the bottom portion of this letter and send it directly to the CAHH office by mail or email.

Patient Signature _____ Date _____

I, _____, am currently treating
(Print Full Name of Doctor)
_____ and acknowledge that he/she is currently receiving
(Print Name of Beneficiary)

(Please check all treatments that apply)

Infusion Chemotherapy / drug name _____
 Oral Chemotherapy / drug name _____
 Radiation Treatment

Date of last treatment _____
If treatment has been completed, what was the last date of treatment? _____

Physician Signature _____ Date _____

Physician Name (Print) _____

Treatment Facility _____

Address _____

City, ST, Zip _____

Phone # _____