PHYSICIAN CERTIFICATION FORM

The applicant below has applied for services from the Edward M. Calvo Cancer Foundation.

THE APPLICANT/GUARDIAN, BY SIGNING BELOW, HEREBY GIVES PERMISSION TO HIS/HER PHYSICIAN TO RELEASE THE HEALTH INFORMATION LISTED BELOW:

APPLICANT NAME (LAST, FIRST, M.I.)		**APPLICANT DATE OF BIRTH**
ADDRESS		
PHONE NUMBER	**SIGNATURE**	**DATE**

PLEASE HAVE THE PHYSICIAN COMPLETE THE FOLLOWING AND RETURN THE COMPLETED FORM TO THE EDWARD M. CALVO CANCER FOUNDATION OFFICE OR EMAIL admin@emccancerfoundation.org.

PHYSICIAN CERTIFICATION

PATIENT'S NAME (LAST, FIRST, M.I.)

THIS PATIENT: ☐ HAS ACTIVE CANCER OR ☐ IS IN REMISSION

DIAGNOSIS: (SPECIFY TYPE OF CANCER)

PHYSICIAN'S NAME ____________________________________

CLINIC NAME AND ADDRESS ____________________________________

____

CLINIC PHONE (671) ____________________________

PHYSICIAN'S SIGNATURE ____________________________________

PHYSICIAN'S MEDICAL RUBBER STAMP

DATE ________________________
(must be within 60 days of submission of the application to the Edward M. Calvo Cancer Foundation)

FOUNDATION OFFICE
138 Martyr Street,
Hagatna, Guam 96910

E-MAIL
admin@emccancerfoundation.org

CHECK RECEIVED BY: (PRINT NAME AND SIGN)
DATE:
---EMCCF USE ONLY---
GRANT ISSUED ON:
CHECK NO.

REVISED 1/2020