GYNCA
GYN CANCERS ALLIANCE
Education. Support. Resources.

How Can GYNCA Help Your Journey? **Newsletter ___** **Mentor ___** **Resources ___** **Financial ___** **All ____**

Member Information: □Single □Partnered □Married □Divorced □Widowed

Name: _____ DOB: _____

Address: _____ County You Reside In: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Place of Employment: _____

Diagnosis/Type of Cancer:_____ Date of Diagnosis:_____ / _____

Attending Physician: _____ Hospital: _____

Race/Ethnicity (used only for statistical purposes): □African American □American Indian □Asian/Pacific Islander □Hispanic/Latino □Caucasian □Other

How did you learn of GYNCA: _____

If you are not available, who would you like us to call? They can also receive/provide your information to us.

Name:_____ Relationship:_____ Primary Phone:_____

Name:_____ Relationship:_____ Primary Phone:_____

Is there any other information you would like to share (medical, financial, prognosis, etc.):

_____

_____

Signed By Member: _____ Date: _____

By signing this form, you grant GYN Cancers Alliance permission to get updates from your doctor as needed to verify treatment for Non-Medical Financial Assistance for 3 years from date signed.

Send completed form to GYN Cancers Alliance, 3039 S Fort Avenue Suite A, Springfield, MO 65807 or email to info@gynca.org.
Please do not fax this form, as the fax will come through as a black page.