-MEDICAL CERTIFICATE-

To be completed by the physician's office & returned to GYNCA by mail or email to info@gynca.org

Patient's Name: _____ Date of Birth: _____

GYN Cancers Alliance provides financial assistance to gynecologic cancer patients who meet its criteria. To determine if the above-named individual meets GYNCA's criteria, your physician's office must provide the following information. There is never a guarantee that we will be able to assist anyone with all financial requests. **FINANCIAL ASSISTANCE ALWAYS DEPENDS ON GYNCA'S AVAILABLE FUNDS.**

All non-medical financial assistance requests are subject to (1) If you are currently in treatment receiving chemo/radiation, (2) Subject to board approval, and (3) If GYNCA has cash flow/funds available.

NEXT CHEMO/RADIATION APPOINTMENT DATE & TIME:

PATIENT'S PHONE NUMBER:

PATIENT'S CITY & STATE OF RESIDENCE FOR RESOURCE GUIDES:

CANCER DIAGNOSIS WITH STAGE/GRADE (Ex: Ovarian - Stage IIIC):

DATE OF DIAGNOSIS:

HOW OFTEN ARE CHEMO/RADIATION APPOINTMENTS:

PROGNOSIS (including temporary, progressive, permanent, recommended treatment, etc.):

COMMENTS:

The foregoing is made under oath or affirmation and its representations are true and correct to the best knowledge and belief of the undersigned subject to the penalties of making a false affidavit or declaration. Provider to complete the information below and return to GYNCA. Please print legibly, or attach a current medical diagnosis report.

Signed: _____ Date: _____ Telephone: _____
(Physician or Physician's Representative)

Printed Name: _____ Hospital: _____

Address:_____ City, State Zip: _____

Email: _____ Fax #: _____

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.