Physician Form

Patient Advocate Foundation
Scholarship for Survivors
Diagnosis Verification Form
To be completed by treating physician

The information requested below is necessary to complete the patient's application to PAF's *Scholarship for Survivors*.

Treating Physician Information

Physician Name: _____

Facility/Practice Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **Ext:** _____ **Fax:** _____

Tax ID Number: _____

NPI Number: _____

Physician Email: _____

Office Contact Name: _____

Office Contact Email: _____

Diagnosis and Treatment Information

Patient's Primary Diagnosis: _____

Date of Diagnosis: _____

Began Treatment or will begin treatment on: _____

Ended Treatment or will end treatment on: _____

Please mark which of the three categories summarizes the patient's diagnosis:

☐ **Cancer** ☐ **Chronic Illness** ☐ **Debilitating Disease**

Physician Attestation

I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of Patient Advocate Foundation's *Scholarship for Survivors*, its representatives, and/or agents assigned to assess the patient's eligibility for participation in the Program. I understand that application to and/or approval for the Patient Advocate Foundation *Scholarship for Survivors* does not guarantee financial assistance.

Physician Signature: _____ Date: _____

If you should have any additional questions, please contact Patient Advocate Foundation.

PATIENT ADVOCATE FOUNDATION
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