Oncology Office Certification

This form is to be completed by your oncologist.

I certify that _____ (patient name) is **actively** being treated for

_____ (diagnosis).

Treatment type: (Please check all that apply):

_____ IV Chemotherapy

_____ Oral Chemotherapy

_____ Immunotherapy

_____ Surgery

_____Radiation Therapy

The patient is expected to be under **active** treatment for _____ (time frame).

Treating Physician Name (printed): _____

Oncologist's Signature (or authorized representative): _____

Date Signed: _____

Must be dated within 60 days of application. Applications without a time frame will not be considered.