Full of Hope Foundation

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.