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: _____ **

Date Signed: _____ ***

*Due to the charter of our foundation, we need a concrete time frame on the oncology certification form. For lifelong treatments, this could be the timeline of the specific medication, chemotherapy, or a date of review of treatment. We cannot accept a form that states "lifelong," "indefinite," or "undetermined," or similar wording. Applications without a date or time frame will be denied.
** Signature must be from the MD, PA, or NP. Unfortunately, we cannot accept certification forms that are signed by an RN or social worker.
***Must be dated within 30 days of application.