



Medical History Verification Form

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*To Be Completed by Physician / Nurse Practitioner:*

I, \_\_\_\_\_, verify that \_\_\_\_\_,  
(Practitioner Name) (Applicant's Name)

is under the care of \_\_\_\_\_, at \_\_\_\_\_,  
(Primary Practitioner) (Institution)

from the dates of \_\_\_\_\_ to \_\_\_\_\_ for a diagnosis of \_\_\_\_\_

Protocol: e.g., last day of chemo/radiation

(Start of Protocol) \_\_\_\_\_ (End of Protocol) \_\_\_\_\_

Please check which ONE of the following criteria is met by this patient:

\_\_\_\_ Completed planned treatment with no evidence of disease

\_\_\_\_ In remission and on long-term hormonal therapy or long-term targeted therapy

(please specify): \_\_\_\_\_

\_\_\_\_ Currently undergoing treatment for a cancer diagnosis

\_\_\_\_ None of these answers apply: explain \_\_\_\_\_

By signing this form, I hereby confirm to Pampered With Purpose that the information provided above is accurate to the best of my knowledge and that the individual is requesting assistance from Pampered With Purpose and is currently receiving treatment for an oncological disease.

Physician/Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License Number of Above Mentioned Physician/Practitioner: \_\_\_\_\_

Patient records are not necessary at this time