



ELLE FOUNDATION INC.
www.ElleFoundation.org
Email: larichmond@ellefoundation.org
P.O. BOX 8068
Bridgewater, NJ 08807-8068
908-393-5529

WISH APPLICATION

PLEASE PRINT CLEARLY

TODAY'S DATE: _____

CHILD'S NAME: _____
(Last) (First)

HOME ADDRESS: _____

CITY STATE ZIP CODE

AGE: _____ **DATE OF BIRTH (with year)** _____ Gender: ___Male ___Female

NICKNAME: _____

MOTHER'S FULL NAME (as it appears on Driver's Lic)

FATHER'S FULL NAME (as it appears on Driver's Lic)

MOTHER'S DATE OF BIRTH (DD/MM/YYYY)

FATHER'S DATE OF BIRTH (DD/MM/YYYY)

DRIVER'S LICENSE NUMBER

DRIVER'S LICENSE NUMBER

DRIVER'S LICENSE EXPIRATION DATE

DRIVER'S LICENSE EXPIRATION DATE

HOME ADDRESS

HOME ADDRESS

HOME PHONE

HOME PHONE

CELL PHONE

CELL PHONE

E-MAIL ADDRESS

E-MAIL ADDRESS

BEST TIME AND NUMBER TO CALL

BEST TIME AND NUMBER TO CALL

CHILD'S NAME: _____
(Last) (First)

SIBLING INFORMATION

FIRST NAME	LAST NAME	AGE	DATE OF BIRTH	GENDER
				___ Male ___ Female
				___ Male ___ Female
				___ Male ___ Female
				___ Male ___ Female

GUARDIAN'S NAME (if applicable, must provide documentation): _____

RELATIONSHIP TO CHILD: _____ **HOME PHONE:** _____

GUARDIAN'S ADDRESS: _____

ORIGINAL DIAGNOSIS

NAME OF FIRST DIAGNOSIS

DATE OF FIRST DIAGNOSIS

HOSPITAL & PLACE OF TREATMENT (include city)

DATE ALL TREATMENTS ENDED

RECURRENCE/CURRENT DIAGNOSIS

RECURENCE DIAGNOSIS

DATE OF RECURRENCE DIAGNOSIS

HOSPITAL AND PLACE OF TREATMENT (include city)

TREATMENT DATES: _____

CHILD'S NAME: _____
(Last) (First)

PHYSICIAN INFORMATION

PHYSICIAN'S NAME **PHYSICIAN'S PHONE NUMBER**

PHYSICIAN'S MAILING ADDRESS

CONTACT AT DOCTOR'S OFFICE **PHONE NUMBER**

CONTACT'S E-MAIL ADDRESS

SOCIAL WORKER/REFERRING MEDICAL CONTACT INFORMATION

SOCIAL WORKER'S NAME **TITLE**

MAILING ADDRESS

EMAIL ADDRESS **PHONE NUMBER**

COMMENTS/ADDITIONAL INFORMATION BY REFERRING MEDICAL CONTACT:

CHILD'S NAME: _____
(Last) (First)

HAS THIS CHILD BEEN GRANTED A FIRST WISH? _____ YES _____ NO

PREVIOUS WISH INFORMATION:

DATE WHEN FIRST WISH WAS COMPLETED: _____

AGE OF CHILD WHEN FIRST WISH WAS COMPLETED: _____

NAME OF WISH GRANTING ORGANIZATION: _____

PHONE NUMBER OF WISH GRANTING ORGANIZATION: _____

BRIEFLY DESCRIBE THE FIRST WISH: _____

HAVE ANY OTHER WISH GRANTING ORGANIZATIONS GRANTED ANY WISHES/ITEMS IN ADDITION TO THE FIRST WISH?

YES _____ NO _____

PLEASE LIST ANY AND ALL ADDITIONAL WISHES/ITEMS RECEIVED BY THIS APPLICANT:

Name of Wish Granting Organization	
Date Wish Granted	
Wish Description	

HAVE ANY OTHER WISH GRANTING ORGANIZATIONS BEEN CONTACTED FOR THE WISH BEING REQUESTED IN THIS APPLICATION?

YES _____ NO _____

IF YES, PLEASE LIST THE NAME OF THE WISH GRANTING ORGANIZATION (S) YOU HAVE CONTACTED:

CHILD'S NAME: _____
(Last) (First)

HOW DID YOU LEARN ABOUT THE ELLE FOUNDATION INC: PLEASE BE SPECIFIC:

CURRENT WISH INFORMATION

WISH BEING REQUESTED: (be specific) _____

DATE OF WISH (Please indicate specific date desired): _____

NUMBER OF PEOPLE TO PARTICIPATE IN WISH: _____
(TRIPS ARE LIMITED TO IMMEDIATE FAMILY MEMBERS – PARENTS AND SIBLINGS**)

I hereby certify that the responses and information provided in this application (and the materials submitted with this application form) are true and accurate to the best of my knowledge. I understand any omission or misstatement can result in the forfeiture of said wish.

THIS DOCUMENT MUST BE SIGNED BY BOTH PARENTS AND/OR LEGAL GUARDIANS

MOTHER'S SIGNATURE DATE

FATHER'S SIGNATURE DATE

GUARDIAN'S SIGNATURE

RELATIONSHIP TO CHILD DATE

**The Elle Foundation is currently unable to grant extensive travel wishes and travel outside of the United States, we are hoping that as our donations grow we will be able to grant more elaborate travel wishes. Please contact the ELLE FOUNDATION for more details.

