**Application Wig**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Address: |  | | |
| City/State/Zip: |  | | |
| Phone Number: |  | | |
| Email Address: |  | Initials |  |

**WIG PROGRAM** – The Cancer Association of Havasu will supply one wig, once a year to any person with cancer related hair loss. The total cost of the wig must be $100 or less, including shipping. Choose a wig from the provided catalog, and we will order online. You may choose to have the wig shipped to the HCHF office or to your home address.

|  |  |  |  |
| --- | --- | --- | --- |
| **1st Choice** | | **2nd Choice** | |
| Style |  | Style |  |
| Color |  | Color |  |
| Size |  | Size |  |

If all three of your measurements do not match exactly to one on the size chart, choose the size that corresponds to the largest measurement.

|  |  |  |  |
| --- | --- | --- | --- |
| Sizes | Around the Head | Front to Back | Ear to Ear |
| Mini Petite (MP) | 20.75 | 12.75 | 12.75 |
| Petite (P) | 21 | 13.25 | 13 |
| Average (A) | 21.5 | 14.25 | 13.5 |
| Large (L) | 23 | 15.25 | 14 |

|  |  |
| --- | --- |
| Cost of wig plus shipping: |  |
| **Minus** Cancer Associations Gift: |  |
| **Participants Amount:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Receipt No. |  | Total: | $ |

I hereby release Havasu Community Health Foundation from all liability. If I do not personally obtain the results of this test, it is my responsibility to contact my physician for said results. This Agreement shall be effective the day it is signed by both parties and expires as posted next to the procedure. If I fail to complete my procedure by the expiration date, HCHF will consider my payment as a donation. I understand I will need to sign a new application and make an additional payment to utilize this program once it has expired. 90 cents of every dollar donated supports your charitable program of choice.

*Payment Method 5 CASH 5 CHECK 5 CREDIT5 SPLIT 5 OTHER*  Check No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confirmation Code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Participant/Caregiver Signature |  | Date |
|  |  |  |
| HCHF Representative |  | Date |