PAUL BERNOT MEMORIAL FOUNDATION

Physician Verification Form

*This form is to be completed by the applicant's oncologist or primary care physician

Dear Physician,

The following applicant has applied for an academic scholarship from the Paul Bernot Memorial Foundation. Your cooperation in verifying the cancer diagnosis of the applicant is greatly appreciated. The applicant does not have to be currently undergoing treatment for cancer, and you do not have to be the physician who treated the patient. This form is to serve as a medical confirmation of a current or prior diagnosis of cancer.

Please complete the form and return it to the applicant. The applicant is responsible for including this form in their application.

Thank you for your assistance in this matter. If you have any questions, please feel free to contact the Paul Bernot Memorial Foundation at foundation@paulbernot.org.

Sincerely,
John Bernot, MD
President, Paul Bernot Memorial Foundation

Applicant Name:_____

Diagnosis: _____ **Year of Diagnosis:** _____

Hospital/Oncology Practice: _____

Current Physician's Name: _____

Practice Address: _____

Phone or email: _____

Physician's Signature _____ **Date:** _____

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