EXPECT MIRACLES FOUNDATION + the samfund

Medical History Verification Form *(Fall 2022)*

Applicant: Please complete Part A, then forward this form to a licensed medical professional.

Part A.

Applicant Name: ______________________________ Date of Birth: ____________

Applicant Email: ______________________________ Applicant Phone: ____________

Part B.

Provider: The abovementioned individual is applying for a Samfund grant. Please complete Parts B and C, below. *When these sections are completed,* ***the form should be returned to the applicant as soon as possible.*** *To ensure that your applicant can complete their application, please do not return this form to Expect Miracles Foundation.*

I, ______________________________ (Practitioner Name), verify that ______________________________ (Applicant Name), was diagnosed with ______________________________ (Diagnosis) on __________________ (Date of Diagnosis). They were under the care of ________________________ (Primary Practitioner), at ______________________________ (Institution), from the dates of _________________ (Start of Protocol) to ____________________ (End of Protocol).

e.g., last day of chemo/radiation

Please do not write "ongoing" or "current" without explanation

Part C.

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

- ____Completed planned treatment with no evidence of disease
- ____One year following the completion of planned treatment with stable disease
- ____In remission and on long-term hormonal therapy, in remission and on long-term targeted molecular therapy, or in remission and on immunotherapy (please specify the medication): ______________________________
- ____This patient does not meet any of these criteria

By signing this form, I confirm that the information provided above is accurate to the best of my knowledge, and that the individual applying for a grant from Expect Miracles Foundation has, at this time, completed treatment for an oncologic/hematologic disease.

Physician/Practitioner Signature: __________________________ Date: ___________

License Number of Above Mentioned Physician/Practitioner: __________________________

Please DO NOT attach the patient's medical records.