Patient Advocate Foundation
Scholarship for Survivors
Diagnosis Verification Form
To be completed by treating physician

The information requested below is necessary to complete the patient's application to PAF's Scholarship for Survivors - Graduate Scholarship Application

To apply to PAF's Scholarship for Survivors Graduate Scholarship, student must have been diagnosed with and/or been actively treated for cancer or a chronic illness within the past ten **(10)** years

Diagnosis is considered active and eligible to apply, if the patient is currently and actively being treated or has been treated for cancer/chronic illness in the past 10 years.

- Scenarios demonstrating active cancer treatment/ chronic illness status include:
- Current chemotherapy, radiation, or anti-neoplasm drug therapy
- Current drug therapy being administered as treatment for chronic illness o Current pathology revealing cancer/ chronic illness
- A newly diagnosed patient awaiting treatment
- Affirmation of current disease management
- The cancerous organ has been removed or partially removed and the patient is still receiving ongoing treatment such as chemotherapy or radiation.
- The patient is currently on adjuvant therapy for prophylactic purposes.

Diagnosis is considered historical and not eligible to apply if:

- The cancer/chronic illness was successfully treated, and the patient has not been in active treatment in the past five years.
- The cancer/chronic illness was excised or eradicated (in the past 10 years) and there's no evidence of recurrence and further treatment isn't needed.
- The patient had cancer/chronic illness over 10 years ago and is coming back for surveillance of recurrence.
- (Annual check-ups)

Diagnosis and Treatment Information

Patient Name:_____

Primary Diagnosis:_____

Has the patient been diagnosed with and/or been actively treated for a cancer, chronic illness within the past **ten (10) years**?

☐ Yes ☐ No

Date of Diagnosis:_____

Began **active** treatment or will begin **active** treatment on:_____

Ended **active** treatment or will end **active** treatment on:_____

Please mark which of the two categories summarizes the patient's diagnosis:

☐ Cancer ☐ Chronic Disease

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Treating Physician Information

Physician Name:_____

Facility/Practice Name:_____

DEA/NPI Number:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Ext:_____ Fax:_____

Office Contact Name:_____

Physician's Office Contact Email:_____

Physician Attestation

I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of Patient Advocate Foundation's Scholarship for Survivors, its representatives, and/or agents assigned to assess the patient's eligibility for participation in the Program. I understand that application to Patient Advocate Foundation Scholarship for Survivors program does not guarantee financial assistance.

Physicians Signature:_____ Date:_____