WE CARE
ENDOWMENT

HEALTH STATEMENT

To be completed by a medical team member familiar with the patient's cancer treatment.

PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____

BIRTH DATE _____

HEALTH STATEMENT

This section is to be completed by a medical team member familiar with the patient's cancer treatment.

TYPE OF CANCER _____

ANTICIPATED LENGTH OF TREATMENT _____

PROGNOSIS OF DISEASE _____

PROVIDER REPRESENTATIVE SIGNATURE _____ DATE _____

PRINTED NAME _____ TITLE _____

I understand that the We Care Endowment will request only that information needed to process and administer this application. We will not disclose the information obtained except as needed for this purpose or as required by applicable law. I hereby represent, covenant and certify as follows that the information contained in this application is complete and accurate to the best of my knowledge. We Care Endowment may revise, change or terminate the grant at any time.

Mail to: We Care Endowment, P.O. Box 21832, Lincoln, NE, 68542.