Your Bosom Buddies II, Inc.
23 D Bedford Court
Royal Palm Beach, FL 33411
Phone: 561-517-0187 Fax: 561-516-7390
www.yourbosombuddies2.org yourbosombuddies2019@gmail.com

Confidential Physician's Statement of Treatment

What kind of Financial Assistance are you applying for? Please be aware that our grants are for diagnostic testing and basic living expenses. If you need further assistance please see our website for additional info.
Please check all that apply.

- ☐ Mammograms
- ☐ Utility Bills
- ☐ Medications/Prescriptions
- ☐ Ultrasounds
- ☐ Medical Bills/Co-pays
- ☐ Food
- ☐ Home Care
- ☐ Lymphedema Supplies

Would you be willing to do some volunteer work for Your Bosom Buddies II, Inc.?

☐ Yes ☐ No

Physician's Statement of Treatment

If currently in treatment, please have your physician complete this basic verification form.

Applicant/Patient Name _____

Patient Date of Birth _____ Patient SS# _____

I am seeking financial assistance from Your Bosom Buddies II, Inc. One of the requirements for assistance is that my physician(s) provide verification that I am currently undergoing treatment.

I give my authorization to release treatment information to representatives of Your Bosom Buddies II, Inc, for the purpose of determining my eligibility for assistance.

Patient Signature _____ Date _____

I, _____ am currently treating _____,
Print Full Name of Doctor *Print Name of Applicant/Patient*

and acknowledge that she/he is currently receiving treatment for cancer in the form of:

- ☐ Radiation
- ☐ Palliative Care
- ☐ Clinical Trial
- ☐ Chemotherapy
- ☐ Surgery
- ☐ Hormonal
- ☐ Bone Marrow/Stem Cell Transplant
- ☐ Alternative/Complementary

Physician Signature _____ Date _____
Physician Address _____ Phone_____
City, State Zip code _____