Your Bosom Buddies II Inc.
23 D Bedford Court
Royal Palm Beach, Florida 33411

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.

- ☐ **Mammograms**
- ☐ **Ultrasounds**
- ☐ **Child care**
- ☐ **Home care**
- ☐ **Utility Bills**
- ☐ **Medical Bills/co-pays**
- ☐ **Lymphedema supplies**
- ☐ **Medications/ Prescriptions**
- ☐ **Transportation to/from treatments**
- ☐ **Food**

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 DOB: _____ **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.

Date _____ **Patient Signature** _____

I, _____, am currently treating
(Print Full Name of Doctor)

_____ and acknowledge that he/she is currently receiving treatment
(Print Name of Applicant/Patient)

for cancer in the form of:

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

Physician Signature _____ Date _____

Address _____

City, ST, Zip _____

Phone # _____