CAN
Cancer Alliance of Naples | Serving Collier & Lee Counties

Physician's Statement of Treatment

Patient Name_____

Patient DOB _____ SS# _____ Ph#_____

I, _____, am currently seeking financial assistance from
(Print Beneficiary/Patient Name)
the Cancer Alliance of Naples, Inc. (CAN). One of the requirements for assistance is that my physician(s) provide verification that I am a cancer patient currently in treatment for active disease. Please read and complete the bottom portion of this letter and send it directly to the CAN office by mail and/or facsimile. *CAN provides financial assistance for qualified patients only while they are in active treatment..*

Date_____ Patient Signature _____

……

I, _____, am currently treating
(Print Full Name of Doctor)
_____ and acknowledge that he/she is
(Print Name of Client/Patient)
is currently being treated for _____ Cancer, Stage ____ with the following treatment(s):
(Please check all treatments that apply)

___Infusion Chemotherapy / Drug Name_____
___Oral Chemotherapy / Drug Name_____
___Immunotherapy / Drug Name_____
___Hormonal Therapy / Drug Name_____
___Radiation Treatment
___Hospice, End of Life Care, Name of Hospice_____

Start date of Treatment. _____
Targeted date of treatment completion _____

☐Check this box if patient is in remission or in a maintenance program.
If the above box is checked, please provide an assessment of the patient's disability:
_____
_____

Physician's Signature_____Date:_____
Physician's Name (Please print) _____
Address_____
City _____ST_____ZIP_____
Phone #_____ Fax #_____

Cancer Alliance of Naples
3384 Woods Edge Circle Suite # 102
Bonita Springs FL 34134
(239) 643-Hope (4673)
(239) 643-4616 (fax)
www.canceralliancenaples.com

Cancer Alliance of Naples
3384 Woods Edge Circle Suite # 102
Bonita Springs FL 34134
(239) 643-Hope (4673)
(239) 643-4616 (fax)
www.canceralliancefnaples.com