ROCK COUNTY CANCER COALITION
Caring | Community | Compassion

# Rock County Cancer Coalition
# Diagnosis Verification Form

## Treatment Standard For your *Oncologist to Complete*

**Applicant's Name:** _____

**Type of cancer applicant is diagnosed with** _____

Applicants must have a diagnosis of cancer and be in **active treatment** when funds are requested. Active treatment is defined as the time when therapies are being administered, including surgical procedures, chemotherapy, and radiation. Chemo therapy is defined as IV treatment or some oral chemotherapy to be approved by RCCC. Active treatment does not include long-term hormonal therapies.

**What treatment is the applicant currently receiving?**

☐ **Chemotherapy** ☐ **IV** ☐ **Oral - Name of medication**_____

☐ **Radiation**

☐ **Surgery - Doctors suggested surgical recovery period**_____

**Form can be completed by oncologist medical personnel, but must be signed by the Oncology Physician**
**Oncologist medical personnel name**_____**Direct Phone**_____

**Oncology Provider Signature:** _____ **Date:** _____

**Oncology Provider name printed:** _____

**Hospital/Clinic Name**_____

**Phone Number**_____

Form Updated March 18, 2022