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.

What treatment is the applicant currently receiving?

☐ **Chemotherapy**

Choose one/both ☐ **IV** ☐ **Oral - Name of medication**_____

***Active treatment does not include surveillance, long-term hormone therapy or maintenance therapies.**

☐ **Radiation**

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

Form can be completed by oncologist medical personnel, but must be signed by the Oncology Physician

Name of person completing this form:_____**Direct Phone**_____

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

Oncology Provider name printed: _____

Hospital/Clinic Name:_____

Phone Number:_____