



APPLICATION FOR SPONSORSHIP FOR PROSTATE CANCER

*****Applicant must be in possession of a valid US Visa to be eligible for selection**

DETAILS OF APPLICANT		
Name	Address	Date of application
Date of birth	Employer	Telephone numbers Work# Home# Mobile#
MEDICAL HISTORY		
Date of first diagnosis		
Diagnosis		Stage
Did you have surgery	Type of surgery	Date of surgery
Doctor/ s	Treatment received to date	Date of treatments received
Type of assistance required <input type="checkbox"/> Full Sponsorship Pet Scan <input type="checkbox"/> Partial Sponsorship Pet Scan <input type="checkbox"/> Doctor's visit Other <input type="checkbox"/> _____ ***Applicant must provide evidence to support claim for financial assistance.		
Cost of procedure/doctor's visit \$ _____	Funding required \$ _____ Do you have personal funds to supplement costs <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If yes state insurance company _____ Will your insurers cover part of the costs of the procedure <input type="checkbox"/> Yes <input type="checkbox"/> No



MEDICAL INSTITUTION		
Medical Institution of procedure/doctor's visit	Address of institution	Estimated Date of procedure/doctor's visit
Doctor's name		
Previous Assistance Given: Yes () No () If yes, give date & details _____ _____ _____		
Signature of applicant: _____		
Checked by: _____		
Approved: () Not approved: ()		
Signature of approvers:		
1. _____		
2. _____		
3. _____		
If not approved give reason: _____ _____ _____		

*APPLICATION DOES NOT GUARANTEE APPROVAL.