Dear Doctor,

The Your Story Foundation Medical Relief Fund is a nonprofit organization dedicated to helping patients with financial assistance during cancer treatments. To be eligible, patients must be currently receiving treatment and be able to provide financial need.

Your patient has already enrolled in our program and was approved based on our initial assessment with the patient or his/her advocate. However, as part of our ongoing compliance requirements, the patient's diagnosis must be verified by the treating physician.

As the treating physician, please complete and sign the form below. Completed forms can be emailed to ***ysfmedicalrelief@yourstoryfoundation.com*** or mailed to:

Your Story Foundation
1202 12th St
Anacortes, WA 98221

I certify that I am the treating physician for _____ (Patient Name)

The patient's primary cancer diagnosis _____

_____

Date of Diagnosis: _____

I further certify that the above named patient is currently undergoing active treatment with chemotherapy and/or targeted treatment medications to treat his/her primary cancer and I will be overseeing the patient's treatment accordingly.

Prescribing Physician:

First Name _____

Last Name _____

Address _____

City _____ State _____

Zip Code _____ Phone _____

NPI # _____

Physician's Signature _____

Date _____