Roots & Ribbons
FOUNDATION

Application for Financial Assistance

Print Name _____ Date _____

Physical Address _____ Zip Code _____ T-shirt size _____

Email: _____ Phone #: _____

How did you hear about us? Friend Facebook Marketing Card Other (specify)_____

I acknowledge that the section below must be completed by the Physician and emailed or faxed to Roots & Ribbons by the physician's office with an attached pathology report.

Applicant Signature: _____ Date: _____

This section to be completed by *Physician ONLY:*

I confirm that the applicant above was diagnosed with Stage _____, _____
(Diagnosis)

_____ Breast Cancer on _____ and is currently under my care.
(Date of Diagnosis)

Attending Physician Name (Printed): _____

Attending Physician Signature: _____ Date _____

Name of Physician's Group/ Practice: _____ Phone # _____

Contact Information for R&RF Verification Purposes: By Fax, Phone #: _____

or By Email to: _____

Your doctor's office is required to return your application to Roots & Ribbons Foundation by email to rootsandribbonsfoundation@gmail.com OR by Fax to 985-395-9578.

Administrative Use Only Application Approved Application Denied

Signature _____ Date: _____

VISA card Amount _____ Date: _____ Delivered by: _____

Recipient Signature _____ Printed Name _____