



Office Use Only: Patient Number: _____
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*Cancer Fears Me* Designated Patient Fundraising  
Patient Verification Form

Designated Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Patient Legal Guardian (if under 18): \_\_\_\_\_

Please make my checks payable to: \_\_\_\_\_

And send to - Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of original diagnosis: \_\_\_\_\_

Current cancer diagnosis: \_\_\_\_\_

Is this a current patient?: \_\_\_\_ If not, when did they complete treatments? \_\_\_\_\_

Name of physician: \_\_\_\_\_

Patient or Guardian Signature:

I verify the above to be correct and authorize you to confirm this with the  
hospital: \_\_\_\_\_ Date: \_\_\_\_\_

The above information will be kept confidential. Only your patient # will be given to those raising money for you.

<p><b>Hospital Verification Statement</b> Must be completed by Physician, Nurse, Social Worker or Child Life Staff Above information must be filled in correctly before you can sign your verification.</p> <p>Your Name: _____ Position: _____</p> <p>Hospital: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____ Email: _____</p> <p>Signature: _____ Date: _____</p>
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Please return this form to:

Cool Kids Campaign  
Cancer Fears Me DPF  
9711 Monroe Street  
Cockeysville, MD 21030

Phone: 410-560-1770 Fax: 410-560-1775  
www.coolkidscampaign.org  
www.cancerfearsme.org