

Date: _____

To: Jamestown Families Cancer Care
P.O. Box 35
Jamestown, OH 45335



Dear Sir/Madam:

I, _____, hereby confirm that _____, DOB: _____,
Doctor's Name **Patient's Name**
is going through cancer treatment. Please complete the following information and sign the Form.

Cancer Diagnosis: _____

Date of Initial Cancer Diagnosis: _____

Name of cancer treatment facility: _____

Please check the appropriate box below, and include the patient's active cancer treatment OR maintenance therapy treatment plan, whichever applies:

Active Cancer Treatment – defined as cancer treatment that may include surgery, chemotherapy, radiation, and immunotherapy. **Please include the patient's current treatment plan in the space provided:**
Frequency of Doctor's Appointments: _____

Maintenance Therapy – given after the initial treatment, maintenance therapy is intended to prevent cancer from returning or to maintain remission. It can also be used to delay the cancer's return. Maintenance therapy can last for ten (10) years or more. **Please include the patient's current maintenance treatment plan in the space provided:**
Frequency of Doctor's Appointments: _____

Sincerely,

Doctor's Signature

Doctor's Printed Name

Name and Address of Facility: (Stamp is Accepted)

This information is to help provide financial assistance for the above patient.

Patient's signature for consent of release of information

Upon completion, this form may be emailed to: jamestownfamiliescc@gmail.com or mailed to Jamestown Families Cancer Care, P.O. Box 35, Jamestown, Ohio 45335

Eff. 7/3/25