CAN Cancer of Harney County Enrollment Form

Community Assistance for Neighbors with Cancer

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Primary Care Provider: _____

Type of Cancer: _____

Type of Treatment:

- ☐ Radiation
- ☐ Surgery
- ☐ Chemotherapy
- ☐ Hormone Therapy
- ☐ Other _____

Facility Providing Treatment _____

Treatment Physician Name (if known) _____

Insurance: _____

Address: _____

_____

Mailing Address (if different) _____

_____

Home Phone _____

Mobile Phone _____

Email _____

Emergency Contact (name and phone) _____

Are you interested in joining the CAN Cancer Support Group?

- ☐ Yes
- ☐ No

CAN Cancer of Harney County
Enrollment Form, cont.

PATIENT ATTESTATION

I hereby certify that I am a resident of Harney County, Oregon and am in need of financial assistance while undergoing medical treatments for cancer. (Medical treatments include radiation, cancer-related surgeries, chemotherapy, or hormone therapy. Other treatments will be considered on an individual basis.)

Patient Signature _____

Date _____

MEDICAL PROVIDER CONFIRMATION

This is to certify that _____ **(DOB:** _____ **)**
PATIENT NAME

has a current cancer diagnosis and will be receiving cancer treatment.

Medical Provider Signature _____

Date _____

APPROVAL

CAN Cancer Coordinator Signature _____

Date _____