Oncology Office Certification

This form is to be completed by your oncologist.
I certify that _____ (patient name) is **actively** being treated for

_____ (diagnosis).

Treatment type: (Please check all that apply):

_____ IV Chemotherapy
_____ Oral Chemotherapy
_____ Immunotherapy
_____ Surgery
_____Radiation Therapy
The patient is expected to be under **active** treatment for _____ (time frame). *

Treating Physician Name (printed):

_____

Oncologist's Signature: _____ **

Date Signed: _____ ***

We need a concrete time frame on the oncology certification form. We cannot accept a form that states "lifelong," "indefinite," or "undetermined," or similar wording. Applications without a date or time frame will be denied.
** Signature must be from the MD, PA, or NP. Unfortunately, we cannot accept certification forms that are signed by an RN or social worker.

***Must be dated within 45 days of application.