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.

I authorize Cancer Connections and its representatives to contact my healthcare provider and obtain or verify medical information relevant to my diagnosis and treatment for the purpose of determining eligibility for services and support.

Patient signature
_____