PEDIATRIC BRAIN TUMOR FOUNDATION

DRIVING RESEARCH ∞ SUPPORTING FAMILIES ∞ HELPING CHILDREN

FAMILY FINANCIAL ASSISTANCE GRANT APPLICATION

Parent/Legal Guardian's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____@_____

Diagnosed Child's Name: _____

Diagnosed Child's Date of Birth: _____ Date of Diagnosis: _____

Treating Medical Institution/Hospital: _____

Name of Treating Physician: _____

Is the diagnosed child currently receiving treatment? _____

If the diagnosed child is currently receiving treatment, please provide a brief description of the type of treatment he/she is receiving (*optional*)?

_____

_____

Aside from money, what are some of your other greatest needs?_____

_____

_____

I **(_____agree**) or **(_____ do not agree**) that The N8 Pediatric Brain Tumor Foundation may use photographs of my child/family for any lawful purpose, including, but not limit to for such purposes as publicity, advertising, and website content.

I attest that the information provided above and accompanying this application is true and correct to the best of my knowledge.

_____

Signature of Parent/Guardian - Date