

# CANCER FREEZE™ APPLICATION

## *Freezin' For A Reason*

Please fill out the following application completely and mail to: **Cancer Freeze / P.O. Box 92 / Florala, AL 36442**

Recipients are chosen on a needs basis. Because of the limited funds available and the number of applications submitted, the Cancer Freeze Board of Directors reserves the right to choose recipients. To apply, you must meet the following four requirements:

- ❖ Must live within 60 miles of Florala, AL.
- ❖ Must be currently diagnosed with any form of cancer.
- ❖ Must be in treatment at time of submitting application.
- ❖ Must provide a copy of doctor's diagnosis/treatment plan.

DATE \_\_\_\_\_ NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_ NAME OF PARENT/GUARDIAN(S) IF MINOR \_\_\_\_\_

OCCUPATION (SELF/PARENT) \_\_\_\_\_

TYPE OF CANCER \_\_\_\_\_

DATE OF INITIAL DIAGNOSIS \_\_\_\_\_ TREATMENT CENTER \_\_\_\_\_

DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

MEDICAL INSURANCE \_\_\_\_\_ CANCER INSURANCE \_\_\_\_\_

CURRENT TREATMENT PLAN \_\_\_\_\_

ASSISTANCE FROM OTHER ORGANIZATIONS \_\_\_\_\_

TELL ME WHY WE SHOULD CHOOSE YOU AS A RECIPIENT:

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Applications are accepted September 1 through October 1 prior to the annual event held the first Saturday of February. Applications will be evaluated by a review board and chosen based on the general needs and circumstances. Proceeds will be presented to the recipient within 30 days after the event. By signing below, you give permission to CF to use your name, picture and story for promotional purposes. Above requirements may be waived at the discretion of the review board.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Parent/Guardian Signature