



**GILDA'S
CLUB
KENTUCKIANA**

An Affiliate of the
CANCER SUPPORT COMMUNITY

Pediatric Financial Assistance Program Application (ages 29 and under) Verification of Treatment

Must be completed and submitted by your doctor, nurse, child life specialist or medical social worker.

Date: _____

Patient information

Patient name: _____ Date of diagnosis: _____

Type of cancer: _____

Information of medical professional completing application

I hereby verify that I am a medical professional and the following applicant
is in **active cancer treatment or within one year post-treatment.**

Printed name: _____ Signature: _____

Phone number: _____ Email: _____

Treatment center/clinic: _____

Mailing address: _____

Please email or mail this form to:

GCKfinancial@gck.org

**Gilda's Club Kentuckiana
Attention: Devon Wasser
2440 Grinstead Drive
Louisville, KY 40204**