

BEDFORD COUNTY PINK RIBBON FUND
Application Form

1. Name: _____
2. Address: _____
3. Telephone number: _____
4. Date and nature of diagnosis, if applicable: _____

5. Name and location of surgeon/oncologist, if currently receiving treatment:

6. Briefly describe your current treatment status (receiving chemo, surgery, reconstruction, radiation, etc.): _____

7. Please describe your current needs (check all that apply):
____ gas cards
____ medical expenses (co-pays, prescription costs, etc., please attach relevant statements)
Please supply physician name and contact information. By providing this information, you are authorizing your physician's office to verify medical expense information to the Fund. Any information received shall remain confidential.

____ medical/treatment supplies (please describe): _____

____ other (please describe): _____

8. How did you hear about the Bedford County Pink Ribbon Fund? _____

Signature

Date

Please direct any questions and submit this Application to:

Dr. Katherine Erlichman
Email: kerlichman@icloud.com

Telephone: 814.285.6844

The Fund reserves the right to make all decisions related to allocation of Fund resources. The Fund does not discriminate on the basis of age, race, color, religion, gender, gender expression, age, nationality, disability, marital status, sexual orientation or military status.