

BEDFORD COUNTY PINK RIBBON FORM

Application Form

1. Name: _____
2. Address: _____
3. Home #: _____ Cell #: _____
4. Email Address: _____
5. SS # (required by law): _____
6. Date & Nature of diagnosis, if applicable _____

7. Name and location of surgeon/oncologist, if currently receiving treatment _____

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

9. Please describe your current needs (check all that apply):
 gas cards
 medical expenses (co-pays, prescription cost, etc., please attach relevant statements)
Please supply the physician's 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): _____

 groceries
 family needs _____
 other (please describe) _____
10. How did you hear about the Bedford County Pink Ribbon Fund _____

Applicant Signature

Date

Please direct any questions and submit this Application to:

Katherine Erlichman, D.O.
Pennwood Ophthalmic Assoc
311 Hospital Drive
Everett, PA 15537

814 285-6844
kerlichman@icloud.com

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, nationality, disability, marital status, sexual orientation or military status.

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