Clayton Dabney for Kids with Cancer
Medical Determination of Qualification

Name of Patient: _____

Name of Parent(s) or Guardian(s): _____

Name of Referring Physician: _____

Physician's Email Address: _____

Referring Office Address: _____

Office Telephone Number: _____
(Physician may attach business card for above information)

I, _____ (Name of Referring Physician), have personal knowledge of the case

of _____ (Name of Patient).

It is my opinion based upon this knowledge along with my evaluation of his/her medical records, that as of the date set forth below

_____ (Name of Patient) will NOT SURVIVE his/her CANCER.

This information is intended only for the internal use of Clayton Dabney for Kids with Cancer and shall be kept confidential.

Signed this _____day of_____, 20____.

_____
Signature of Physician

_____
Printed Name of Physician