Childhood Leukemia & Lymphoma Foundation

1. Full name and date of birth of the child:

2. His/her family background - 1 to 2 paragraphs (describe social, financial status, family size, parent's occupation, etc.):

3. Diagnosis summary, prognosis and next steps (to be filled by child's treating doctor – please type, do not attach medical records):

4. Why is funding requested for this case – (example, is MPLAD not available, EWS section, lack of/inadequate insurance, etc.) or any other reasons to justify donations?
Provide total estimated cost of treatment, available and committed funds, and the difference that's being requested (to be filled by treating hospital).

I, _____, Parent of _____, resident of _____ understand and agree that 'Childhood Leukaemia & Lymphoma Foundation' may disclose the above information with anyone for purposes of raising funds/donations for treatment and care of my son/daughter, _____, on an ongoing basis. I am voluntarily sharing my son/daughter's photos, which can be used for purposes of raising funds and donations for his/her initial and ongoing treatment.

I also confirm that all the information given on this form is accurate and complete, and nothing has been wilfully hidden for purposes of wrongfully requesting funds.

This form also serves as a formal request on behalf of the child by the parents, the treating hospital and the treating doctor to 'Childhood Leukaemia & Lymphoma Foundation' to raise and donate funds for the required treatment.

The treating hospital agrees to furnish all records of expenses incurred related to the amount donated, and the same will be shared with 'Childhood Leukaemia & Lymphoma Foundation' as and when requested, within 24 hours of a request to provide them by email/in original.

Name, email and phone number of authorised person from the treating hospital - to provide billing reconciliation against funds provided:

Hospital name:
Person's Name:
Designation:
Email:
Phone:

Parent's signature and date:

Treating Hospital's name, signature and date:

Treating Doctor's name, signature and date: