



Cure for Cancers
 3260 Shasta Circle North
 Los Angeles, CA 90065
 Phone 1-866-332-2873
 Fax 323-982-9818
www.cureforcancers.org

PATIENT AID PROGRAM – GYM MEMBERSHIP APPLICATION

Please complete the application form thoroughly and legibly. Some of the information we request will have no bearing on the membership decision but is necessary for statistical purposes. Please note that all information is confidential. The applicant and physician must sign the form for it to be considered complete. The physician/referral section must be filled out completely.

GENERAL INFORMATION

Name _____ Age _____
 First Last
 Street Address _____ Phone _____
 City _____ State _____ Zip _____

Email Address: _____

Social Security Number _____

Check one: Male Ethnicity/Race(optional) _____
 Female

Type of Cancer _____

PHYSICIAN/REFERRAL INFORMATION

Note: Please be sure to have your physician complete and sign this portion of the application.

Physician/Referral _____ Telephone _____

Institution _____

Address _____

Patient Prognosis: _____

Current Method of treatment being used: _____

Physician's Signature _____

GYM/FACILITY INFORMATION

Name of Gym: _____

Address: _____

Phone _____ Fax _____ Email _____

Intended Use (weight lifting, swimming, aerobics, etc) _____

Cost of 6 month membership: _____

FINANCIAL & MEDICAL ASSISTANCE INFORMATION

Income: (Monthly)

Expenses: (Monthly)

Net Income _____

Rent/Mortgage _____

Social Security _____

Utilities _____

Public Assistance _____

Telephone _____

Other Income/Grants _____

Food _____

TOTAL _____

Medications _____

Other _____

Savings (Total)

TOTAL _____

Savings _____

Stocks, Bonds _____

Investments _____

TOTAL _____

Insurance Carrier _____

How did you hear about our Gym Membership program? _____

CERTIFICATION AND DISCLAIMER

I certify that the foregoing information is true and correct. If my application for a Cure for Cancers Gym Membership is accepted, I understand and agree that there are many risks, both foreseeable and unpredictable, associated with a gym and any workout process. I hereby agree that Cure for Cancers, nor its officers, directors, employees, agents, members, or volunteers, shall not assume nor have any responsibility or liability, including without limitation of any kind in connection with this membership liability for expenses or medical treatment or compensation for any injury I may suffer during or resulting from my use of the Gym Membership and gym facilities. I do hereby, for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my use of this Gym Membership. I give Cure for Cancers or their designee permission to contact my physician (nurse/social worker when applicable) based on the information I have provided within this grant application. I will comply with any rules or restrictions related to the terms of this membership if I should be a recipient.

Signature _____ Date _____

Please return this complete form and mail it to:
Cure for Cancers
3260 Shasta Circle North
Los Angeles, CA 90065
Phone 323-982-0068 Fax 323-982-9818