APPLICATION

ANGELS ON ASSIGNMENT

A Nonprofit Volunteer Organization Dedicated to Helping Children by Providing Solutions for Families with a Seriously Ill Member

Applicant Name:_____

Parent or Legal Guardian:_____

Home Address:_____

City:_____State_____Zip_____

Home Phone Number:_____Cell:_____

Date of Birth: _____

How Many People Reside in Your Home? _____

Please list the name, age and relationship of each person that lives in your home:

Name	Age	Relationship

Name & Address of Treating Physician

_____

_____

_____

_____

Phone # of Treating Physician

_____

Please include a letter from your physician stating the diagnosis for our verification.

Diagnosis:_____

History of Illness:

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How Can Angels on Assignment Be of Help to Your Family?

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Do you know any other fund-raisers planned for your family? _____

Are you receiving help from any other agency or organization?_____

If so, which agency or organization?_____

I have recorded information on this application which is true, to the best of my knowledge and belief. I understand that I may be asked to obtain documentation supporting my medical history from my primary care physician.

Signature_____Date _____
(applicant, parent or guardian)

NOTE: Photos may be taken at our public events and posted on our website. We can remove upon request.