CANCER CONNECTS

Complementary Therapy Voucher Application

Name: _____ Date of Birth _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone number: _____

What is your cancer diagnosis?:_____

When were you diagnosed?: _____

Name of oncologist: _____

Are you currently undergoing treatment? YES NO

If so, what type?

CHEMOTHERAPY RADIATION HORMONE OTHER _____

Have you completed treatment? YES NO If so, when_____

In which therapy are you interested? (Please select only **ONE**)

MASSAGE THERAPY REIKI THERAPY HEALING TOUCH

FOOT REFLEXOLOGY ACUPUNCTURE

Tell us why you are interested in this program (please feel free to continue on back of form if needed): _____

_____

_____

_____

_____

_____

_____

_____

_____

Please return your completed application to
CancerConnects • P.O. Box 2010 • East Syracuse, NY 13057

Disclaimer: Awarding of vouchers subject to availability of funds