Greater Richland Area Cancer Elimination, LLC
Director of Local Cancer Patient Assistance
PO Box 213, Richland Center, WI 53581
608-604-2900
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Website: walkwithgrace.com

DIAGNOSIS VERIFICATION FORM

Must be completed by a physician or physician representative

I hereby confirm that _____ has a
(Patient Name)

current cancer diagnosis of _____ and

is/will be receiving treatment related to this cancer.

_____
Physician/Provider Name (Please Print)

_____
Physician/Provider Signature

_____
Hospital/Clinic

_____
Phone Number

_____
Date