Fitzgerald Cancer Fund
Battling Neuroblastoma BETTER
A 501(c)3 Public Charity

Amount Requested: ☐ **$500** ☐ **$1000**

Primary Purpose:

Neuroblastoma Parent/Caregiver Grant Application

Please tell us about you and your child:

Patient Name: _____ Age: _____

Birth date: _____ Diagnosis Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Caregiver Name(s): _____

Phone: _____ Cell: _____ Email: _____

What is your preferred method of contact? _____

Please tell us about your child's treatment:

Treating Facility: _____

Facility Address: _____ Phone: _____

Oncologist Name: _____ Phone: _____

Email: _____

Social Worker Name: _____ Phone: _____

Email: _____

Please attach a short response to the following questions:

Tell us about your family. How has life changed since your child's diagnosis?

How would this grant help your family? What need would it fulfill for your family?

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Photography and Promotional Release

Please select below and sign the following release to allow the Fitzgerald Cancer Fund, Inc. to use the patient and family's names, story and images to help raise awareness for the Fitzgerald Cancer Fund, Inc. and Neuroblastoma.

(Please read the following, choose an option, and sign at the bottom)

I hereby release and discharge the Fitzgerald Cancer Fund, Inc. from any and all claims and demands arising out of or in connection with the use of images, media and information, including without limitation any and all claims for libel or invasion of privacy.
I hereby authorize and consent to the use of said material by the Fitzgerald Cancer Fund, Inc. for appropriate purposes, including but not limited to: any printed matter, in any and all media now or hereafter known, and for any purpose whatsoever, for illustration, promotion, art, editorial, advertising and trade, or any other purpose whatsoever without restriction as to alteration.

☐ Yes, I agree to allow the Fitzgerald Cancer Fund, Inc. to use our information.

☐ No, please keep our family's information confidential.

Parent/Legal Guardian Name (please print): _____

Signature: _____ Date: _____

Required Attachments

☐ Attach photographs of the patient before and after his/her diagnosis. (If "Yes" checked)

☐ Attach a letter on Facility/Hospital Letterhead verifying the patient's diagnosis written and signed by the treating oncologist and/or hospital social worker.

☐ Your responses to the questions on page 1 of this application.

☐ A signed, personal statement demonstrating your family's financial need for an FCF grant.