APPLICATION

CLINICAL TRIALS PARTICIPATION SUPPORT

SFA SARCOMA FOUNDATION of AMERICA

PATIENT INFORMATION

Patient's Name ..... Date of Birth .....

Patient's Street Address ..... State Zip .....

Patient's Phone Number ..... Patient's Email Address .....

Type of Sarcoma ..... Date of Diagnosis ..... Does the patient have health insurance? ❍ Yes ❍ No

Insurance provider and policy # .....

REPRESENTATIVE INFORMATION (if person completing the application is different than the patient):

Name .....

Street Address ..... State Zip .....

Phone Number ..... Email Address ..... Relationship .....

PREVIOUS CANCER TREATMENT: (check all that apply)

Chemotherapy: ❍ Yes ❍ No

If yes which types of chemotherapy:

.....

Radiation: ❍ Yes ❍ No

Surgery: ❍ Yes ❍ No

Immunotherapy: ❍ Yes ❍ No

Previous Clinical Trial: ❍ Yes ❍ No

HOW DID YOU LEARN ABOUT THIS FUND?

❍ Internet

❍ Physician Nurse

❍ Social Worker Support Group

❍ Other: .....

HOUSEHOLD INCOME INFORMATION

Is patient currently employed? ❍ Yes ❍ No Place of Employment: .....

INCOME SOURCES (please select all that apply)

❍ Salary/Wages ❍ Social Security (retirement) SSI ❍ SSD (disability) Unemployment

❍ Public Assistance ❍ Short-term disability ❍ Other (please specify): .....

FINANCIAL ASSISTANCE REQUESTED

Ground Transportation (Uber, Taxi, Lyft, Rental, Train) Total: Mileage / Parking / Tolls Total: .....

Lodging Total: ..... Air Travel Total: ..... Other (please specify): .....

Total Amount requested (up to $5,000): .....

TOTAL ANNUAL HOUSEHOLD INCOME: .....

NUMBER OF PEOPLE IN HOUSEHOLD: .....

PHYSICIAN CONFIRMATION

This section must be completed and signed by your clinical trial medical professional (oncology nurse, doctor, social worker, clinical trial coordinator).

Patient Name:

Primary Cancer: Primary Cancer Stage:

Clinical Trial Doctor / PI:

Direct Phone Number of Doctor / PI:

Email Address: Clinical Trial Clinic/Hospital:

Clinical Trial Address: State Zip

Clinical Trial Sponsor Company:

Clinical Trial NCT # (Required for assistance):

Clinical Trial Name:

Is patient currently receiving financial reimbursement from clinical trial sponsor? ❍ Yes ❍ No

If yes, is this a stipend for participation? ❍ Yes ❍ No Amount: # of payments/frequency:

Is this a reimbursement for travel expense? ❍ Yes ❍ No ❍ One time only ❍ Every visit If so, what type of travel?

Ground Transportation (Uber, Taxi, Lyft, Rental, Train) Mileage / Parking / Tolls Lodging Air Travel

Other (please specify):

NAME AND RELATION OF CLINICAL TRIAL REPRESENTATIVE COMPLETING THIS SECTION (if different than above)

Name

Phone Number Email Address

Signature of Clinical Trial Representative: Date

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