Clayton Dabney Foundation for Kids with Cancer
Medical Determination of Qualification

Name of Child: ____

Name of Parent(s): ____
Or Guardian(s): ____

Name of Physician: ____

Office Address: ____

Office Tel. Number: ____

Office Fax Number: ____

E-Mail Address: ____
(Physician may attach business card for above information)

I, ____(name of doctor), have personal knowledge of the case of ____(name of child).

It is my opinion based upon this knowledge, along with my evaluation of his/her medical records, that as of the date set forth below,________________________________(name of child) will NOT SURVIVE his/her CANCER.

This information is intended only for the internal use of the Clayton Dabney Foundation for Kids with Cancer and shall be kept confidential.

Signed this______ day of ____________________,200__.

____
Signature of Physician

____
Print Name of Physician