



DEATH VALLEY WALK FOR LIFE

INCORPORATED

Application for Financial Assistance

1. I _____ am receiving Cancer Treatments from Doctor: _____ at the following location: _____.
2. I am making application to Death Valley Walk For Life Inc., to request financial assistance to help cover my Medical expenses incurred for my Cancer Treatment and or expenses incurred seeking Medical treatment.
3. I release permission to the Executive Board of Death Valley Walk for Life to make copies of the Medical or expense reports that I am submitting for financial assistance.
4. I authorize the Death Valley Board of Directors to contact my Doctor and the Medical facility to verify that I am receiving Cancer treatments.
5. In doing so I understand that I may receive financial assistance from your Organization. Otherwise financial assistance will be denied.
6. I wish to receive financial assistance in the amount of: _____.
7. I also understand that limited financial assistance will be dependent upon the amount of funds available at the time of my application.

Signed: _____ this ____ day of _____ 2009