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www.kissesforkyle.org

____________________________ Supporting families battling childhood cancer_________________________

REQUEST FOR ASSISTANCE

Name of child: ______________________________________ **DOB:** ______________________

Child's social security number: __________________________

(If child doesn't have SS#, please use parent or guardian's and indicate)

Address: ____

City: __________________________ **State:** ________________ **Zip Code:** ______________

Telephone number: ___________________________

Diagnosis of illness: ____

Date of diagnosis: ______________________________

Name of parent or guardian: ____

Name of primary Oncologist: ____

Amount of request: _____________________________

Purpose of request: ____

Social Worker's name: ______________________________**telephone number:**__________________

Date of application:_____________________________

I ____**have reviewed the information on this application and to the best of my knowledge this information is true and complete.**

Social Worker signature: ____