

**LAFAYETTE COUNTY CANCER COALITION
TRANSPORTATION REIMBURSEMENT ASSISTANCE FORM**

I CERTIFY THAT _____ CURRENT DATE _____
(Patient's Name)

_____ PHONE # _____
(Patient's Complete Address)

IS A CANCER PATIENT UNDER MY CARE AND THEY NEED THE FOLLOWING SERVICES:

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TRANSPORTATION REIMBURSEMENT ASSISTANCE FOR CHEMO/RADIATION TREATMENTS

TRANSPORTATION REIMBURSEMENT ASSISTANCE TO DOCTOR'S APPOINTMENT AND/OR OTHER TESTS RELATED TO THE CANCER TREATMENT.

TO _____
(Treatment Center)

BEGINNING DATE: _____
ENDING DATE: _____

FOR A TOTAL OF _____ TRIPS

DOCTOR'S NAME: _____
(Please print)

DOCTOR'S SIGNATURE: _____

**RETURN COMPLETE FORM TO: LAFAYETTE COUNTY CANCER COALITION
C/O LOIS WILEY, 402 W. 34TH ST, HIGGINSVILLE, MO 64037
Questions?**

**PHONE: Lois Wiley: 660-238-2060
Tom Wiley: 660-232-0590**

(visit us on Facebook and on www.lafcocancer.org for more information and other forms)