LAFAYETTE COUNTY CANCER COALITION
TRANSPORTATION ASSISTANCE

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:

(__) TRANSPORTATION REIMBURSEMENT ASSISTANCE FOR CHEMO/RADIATION TREATMENTS

(__) TRANSPORTATION REIMBURSEMENT ASSISTANCE TO DOCTOR'S APPOINTMENT AND/OR OTHER PROCEDURES RELATED TO THE CANCER TREATMENT.

TO _____
(Treatment Center)

BEGINNING DATE: _____

ENDING DATE: _____

FOR A TOTAL OF *_____ TRIPS

*For future dated trips totaling 26 or more, half will be paid now with half being paid once treatment is complete. Please contact us once treatment has been completed. Documentation of trips may be requested.

DOCTOR'S NAME: _____
(Please print)

DOCTOR'S SIGNATURE: _____

RETURN COMPLETED FORM TO:

LAFAYETTE COUNTY CANCER COALITION
C/O LOIS WILEY
402 W 34TH ST
HIGGINSVILLE, MO 64037

Questions? Please call: Tom Wiley (660) 232-0590
Lois Wiley (660) 238-2060

Visit us at www.lafcocancer.org for more information and other forms. We are also on Facebook.

I certify I am a permanent resident of Lafayette County, Missouri.

_____
(Patient's signature)

11/2021