Genevieve's Helping Hands, Inc.
resources for young women with breast cancer

Medical Verification

To be completed by a member of the
Patient's Medical Team

Date: _____

Name of Patient: _____

Home Address of Patient: _____

Date(s) of Treatment(s): _____

Type of Treatment(s): _____

Location of Treatment(s): _____

If applicable, recommended optimal recovery time outside of the hospital:
_____

Your Name and Title: _____

Address: _____Tel. Number: _____

E-mail: _____

Comments: (Optional) _____

Signature: _____ Date: _____

The Genevieve Memorial Grant Criteria

For young mothers first diagnosed with breast cancer at age 40 or younger
For young mothers starting breast cancer treatment, in treatment, or recovering from treatment
To be applied at mutually agreed upon dates and a location arranged by Genevieve's Helping Hands, Inc.