



ROFEH CHOLIM CANCER SOCIETY

768 BEDFORD AVENUE BROOKLYN, NY 11205
TEL (718) 722-2002 FAX (718) 722-4757

APPLICATION CLERGY / _____

NAME OF PATIENT _____

ADDRESS OF PATIENT _____

TEL. # OF PATIENT _____

NAME OF CLERGYMAN _____

NAME OF INSTITUTION / ORG. _____

ADDRESS OF CLERGYMAN _____

TEL. # OF CLERGYMAN _____

I hereby attest that the aforementioned patient, residing at the address indicated above, is affiliated with my institution / organization.

I am aware that (s)he has been diagnosed with cancer and that (s)he cannot afford to pay health insurance premiums.

SEAL OR
NOTARY OF
SIGNATURE

SIGNATURE OF CLERGYMAN _____

DATE _____

Additional Notes
