



www.believeinmiracles.org

## APPLICATION FORM

### Patient Information

Child's Name			Date Submitted		
Address			Home Phone		
Parent(s)/ Guardian(s)			Cell Phone		
E-mail Address		Date of Birth		Age	Gender
Hospital	Physician		Nurse/Social Worker		
Physician Phone #:		Physician Fax #:			
Diagnosis		Child lives with: Mother      Father      Both Parents      Guardian			
Siblings Information: Name		Relationship		Date of Birth	
_____		_____		_____	
_____		_____		_____	

### Trophy Recipient Request

<p style="text-align: center;"><i>Believe in Miracles primarily helps children who have had a recurrence or an ongoing medical condition. We serve as an enhancement for children who have already received a wish from a wish granting organization, but who are still battling their disease and could really use something to brighten their day. Believe in Miracles will meet the needs of suffering children by providing necessities or a fun-filled gift.</i></p>
<p>Has the patient received a gift from any other organization, agency and/or foundation? If so, list agency/foundation and nature of assistance, and approximate date the gift was received:</p>
<p>How were you referred to Believe In Miracles?</p>
<p>Trophy Recipient Request:</p>