Application Form

1977 E. Wattles * Troy, MI 48085
Ph: 248-633-5109 Fax (248) 608-4838
www.believeinmiracles.org

Patient's Name			Date Submitted
Address	City	Zip	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, Guardian)		

Siblings Information: Name	Relationship	Date of Birth

Has the patient suffered a recurrence or change in medical condition? (Y/N) _____

Has the patient received a wish from a wish granting organization? (Y/N) _____

If so, name the organization that granted the wish: _____

List wish and the approximate date the wish was granted: _____

Your Name:	Your Phone #:
Your E-mail:	
Your Relationship to the Child:	
How were you referred to JK Believe In Miracles?	
Trophy Recipient Request:	

JK 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.

Parent/Guardian Certification

I, _____, certify that the information provided in the application is true and correct as of the date set forth opposite my signature. I also certify that out treating physician has approved the application request.

JK Believe in Miracles reserves the right and the applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis. The applicant understands that the Trophy Recipient's story and medical information my be included on JK Believe in Miracle's website or the like for inspiration and encouragement.

The applicant gives JK Believe in Miracles permission to publish in print, electronic or video format the likeness or image of child, family and myself. I release all claims against the foundation with respect to copyright ownership and publication including any claim for compensation related to use of the materials.

Parent/Guardian Signature (Patient if over 18)	Date	Relationship to patient

Required Physician Verification

****PLEASE CHECK THE APPROPRIATE BOXES & SIGN BELOW****

Has the above mentioned patient been diagnosed with a life threatening medical condition and is the patient between the ages of 3 and 21 years old?

☐ **YES** ☐ **NO**

Has the above mentioned patient suffered a recurrence, change in condition or an ongoing chronic life threating illness?

☐ **YES** ☐ **NO**

Doctor's Signature	Date

Dr.'s Name (Printed): _____

Address: _____