



Believe In MIRACLES Foundation

### Application Form

2888 E. Long Lake Suite 140 \* Troy, MI 48085

Ph: (248) 633-5109 Fax: (248) 250-6008

[www.believeinmiracles.org](http://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)			
<u>Siblings Information: Name</u>		<u>Relationship</u>		<u>Date of Birth</u>	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
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 a progressive life-threatening medical illness or is between the ages of 18-21 and has not yet received a wish from a wish granting organization..*

## 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 our treating physician has approved the application request and authorize release of my/ my child's medical information for purposes of this application.

\_\_\_\_\_  
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 or change in condition?

YES

NO

Explain the change in condition:

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr.'s Name: (Printed)

\_\_\_\_\_  
Address