Gift Of Hope Application Form

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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		Has the patient received a wish from a WGO? **Yes** ☐ **No** ☐ If so, name the organization:	
Your Name:		Your Phone #:	
Your E-mail:		Your Relationship to the Child:	
Request:			

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. JK Believe In Miracles reserves the right to share all information provided by the applicant to third parties on an as-needed basis. The applicant understands that the patient's story and medical information may be included on our website or the like for inspiration and encouragement. The applicant gives JK Believe in Miracles permission to publish in print, electronic or videoformat 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

Medical Verification

I, _____, certify that the above-mentioned patient was diagnosed with the life-threatening medical condition listed above.

Name/Title printed

_____ _____

Signature Date

Address: