

## **Medical Authorization Form**

The Mesothelioma Applied Research Foundation offers a Patient Travel Grant Program to assist patients with treatment related travel expenses. Applicants are required to have their treating physician, nurse, or social worker complete and sign the attached medical verification form. *An application will not be considered without the completed medical verification form.*

The Patient Travel Grant Program will cover travel-related expenses for individuals who have been in contact with the Meso Foundation prior to the trip. This program does **not** reimburse for travel costs that were incurred over 1 month prior to reaching out to the Meso Foundation.

### Criteria for Participation:

1. An expert consultation after diagnosis of mesothelioma and/or:
2. Clinical trial participation  
Includes but is not limited to:
  - Evaluation for participation in a clinical trial.
  - Exploration of new treatment due to tumor progression.
  - Currently enrolled in a treatment based clinical trial.

Each visit requires a separate travel request. Travel grants will not cover travel for follow-up scans and appointments.

Please submit all application materials to Nicole Yost, Travel Grant Coordinator

**Email:** [info@curemeso.org](mailto:info@curemeso.org)

**Fax:** +1 (571) 363-2784

**Mailing Address:** Mesothelioma Applied Research Foundation,  
1615 L Street NW, Suite 430, Washington, D.C. 20036

**Application Type:**

Initial Consultation with a Specialist    Clinical Trial

**Patient Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Medical Information:**

Date of diagnosis: \_\_\_\_\_

Diagnosis/Cancer site: \_\_\_\_\_

Type of treatment:    Chemotherapy     Radiation     Other (please explain):

\_\_\_\_\_

Frequency (treatments/per week): \_\_\_\_\_

Treatment start date (Current phase): \_\_\_\_\_

End date (Current phase): \_\_\_\_\_

Is the patient enrolled in a clinical trial?    Yes\*     No

**\*If yes, name of clinical trial:** \_\_\_\_\_

Treatment facility: \_\_\_\_\_

Referring professional: \_\_\_\_\_

Treating physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

\_\_\_\_\_  
Treating Physician or Referring Professional's Signature

\_\_\_\_\_  
Date