Mesothelioma Applied® Research Foundation
research - education - support - advocacy

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

Fax: +1 (571) 363-2784

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

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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