KidneyCancerAssociation®

Physician Verification Form

The Kidney Cancer Association (KCA) seeks to be a source of education and resources for patients, caregivers, and anyone impacted by kidney cancer. KCA's Patient Assistance Fund provides assistance to ensure access to care and compliance with prescribed treatments. To be eligible patients must have a physician-verified kidney cancer diagnosis that is actively being treated.

As the treating physician, please complete and sign the form below. **Completed forms should be emailed or handed to the patient.** Please reach out to paf@kidneycancer.org with any questions.

I certify that I am the treating physician for _____ _____

Patient Name **Date of Birth**

The patient's primary cancer diagnosis is _____

Cancer Diagnoses **Date of Diagnosis**

I further certify that the above-named patient is **currently undergoing treatment to treat his/her primary kidney cancer** and I am overseeing the patient's treatment accordingly.

Treating Physician

First Name_____ Last Name _____

Email_____ State_____ Zip Code _____

Phone_____

NPI #_____ Institution Name _____

Physician's Signature_____ **Date**_____