



BOBBY PAGE MEMORIAL FOUNDATION 2008 REQUEST FOR FUNDING APPLICATION

The Bobby Page Memorial Foundation is committed to assisting children throughout the Rome area that are suffering from a life threatening illness. The Bobby Page Memorial Foundation is committed to raising and allocating funds to applicants who fulfill following eligibility requirements: child with life threatening illness who must be under 18 years of age, the family must reside within Rome or vicinity, and physician must provide evidence of illness by submitting the attached "Patient Authorization Form". For questions regarding this application, please call 336-8364.

APPLICATION INFORMATION

Date of Application: _____

Name of Recipient: _____

Date of Birth: _____

School Attending: _____

Name of Applicant (Parent, Guardian, etc.): _____

Relationship to Recipient: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ E-mail: _____

Insured: ___ Yes ___ No

ILLNESS State the Nature of Child's Illness**:

PLEASE ATTACH PATIENT AUTHORIZATION FORM (PAGE 3) SIGNED BY PHYSICIAN

Public Disclosure Waiver:** _____ Yes _____ No

**Applicant agrees to allow the Bobby Page Memorial Foundation to utilize the grantee's "story" for promotion of good works.



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Primary Care Provider: _____

Medical Contact Information (Doctor or Specialist Currently Assisting Applicant)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-mail: _____

****Medical Release of Information: Please forward Patient Authorization Form signed by physician describing medical condition.**

STATEMENT OF NEED

Please give a detailed description concerning the elements of your request:

Please mail application to:

**Bobby Page Memorial Foundation
8527 Cyrus Ave.
Rome, NY 13440**



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I HEREBY AUTHORIZE YOU TO USE OR DISCLOSE THE SPECIFIC INFORMATION DESCRIBED BELOW FOR PURPOSE OF PROVIDING THE "BOBBY PAGE MEMORIAL FOUNDATION" APPROPRIATE INFORMATION TO SUPPORT THE BELOW MENTIONED PATIENT'S APPLICATION FOR FUNDING.

Person requesting the information and authorization to make the requested disclosure on behalf of the patient: _____
Relationship: _____

PHYSICIAN INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Fax: _____ E-mail: _____

RECIPIENT OF THE INFORMATION:

BOBBY PAGE MEMORIAL FOUNDATION
8527 CYRUS AVE. ROME, NY 13440 315-336-8364

Description of specific medical condition (please attach additional documentation if necessary)

Physician Signature: _____ Date: _____