Lazarex
CANCER FOUNDATION

P O Box 741 Danville, CA 94526
Phone: 925-820-4517 Fax: 925-552-7305
www.lazarex.org
REV 332020

Trial Verification Form

Patient Name: ______________________ **Date:** ______________________

THIS SECTION BELOW MUST BE COMPLETED BY YOUR MEDICAL REPRESENTATIVE ONLY
(Oncologist, nurse, doctor, social worker or clinical trial coordinator, etc.)

Clinical Trial Doctor: ______________________

Clinical Trial Clinic/Hospital: ______________________

Clinical Trial Address: ______________________

City, State, Zip: ______________________

Phone Number: ______________________ **Email Address:** ______________________

Clinical Trial Sponsor Company: ______________________

Clinical Trial Name:
NCT #
(Required for assistance)

Phase of Clinical Trial: ☐ Phase 1 ☐ Phase 2 ☐ Phase 3 ☐ Phase 4

Is patient currently receiving financial reimbursement from clinical trial? ☐ Yes ☐ No

If yes, what type?

Treatment Schedule:
(EX: 3 weeks on 3 weeks off)

NAME AND TITLE OF MEDICAL REPRESENTATIVE COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE: **(please print clearly)**

Name: ______________________ **Title:** ______________________

Direct Phone Number: **(no general #s)** ______________________ **Email Address:** ______________________

☐ **I verify that (patient)** ______________________ **is still currently enrolled in the above clinical trial.**

Signature of Medical Representative: ______________________ **Date:** ______________________

Your relationship to person applying for help: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ CT Coordinator Other: ______________________

Fax this form to 925-552-7305 or email to Rnoonan@lazarex.org or mail to Lazarex Cancer Foundation, P. O. Box 741, Danville, CA 94526.

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