



P O Box 741 Danville, CA 94526
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www.lazarex.org
GP TVF - REV 10202021

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 #: _____

Phase of Clinical Trial: [] Phase 1 [] Phase 2 [] Phase 3 [] Phase 4

In addition to Lazarex, is the patient currently receiving financial reimbursement from the clinical trial? Yes No

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

[Empty box for treatment schedule details]

If yes, what type? [Empty box for reimbursement details]

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 PatientServices@Lazarex.org or mail to Lazarex Cancer Foundation, P. O. Box 741, Danville, CA 94526.

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