Lazarex CANCER FOUNDATION

P O Box 741 Danville, CA 94526
Phone: 925-820-4517 Fax: 925-552-7305
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

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