Northern Ontario Families of Children with Cancer

Registered Charity No. 86467 6713-RR 0001

NOFCC Financial Assistance Program

(Please Print Clearly & Fill out form completely)

Child's Name: _____ Birth Date: ____/____/____
First Last Month Day Year

Primary Family Contact: _____ Phone #: _____
First Name Last Name

Reimbursement cheque to be sent to: _____
First Name Last Name

_____
Street Address Apt # City Province Postal Code

Child's Treatment Status:

☐ Active Treatment (period of receiving treatment) ☐ Active Follow Up (start date): ___/___/___ (1 year following end of active treatment) ☐ Relapse (date of relapse): ___/___/____

Date(s)	# of Days	$10/day Local App't	$20/day Out of Town App't	Pediatric Oncology Center	Pediatric Oncology Centre Hospital Signature
Totals:					

Parent Signature: _____ Date: _____

For NOFCC use only:

Cheque #: _____ Issue Date: _____ NOFCC Authorization: _____

**Claims must be sent to NOFCC by the 10th of every month

** Local= within 100km from home **Out of town= beyond 100km from home

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