CANCER CONNECTS

Complementary Therapy Voucher Application

Name: _____ Date of Birth _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

What is your cancer diagnosis?:_____

When were you diagnosed?:_____

Name of oncologist: _____

Are you currently undergoing treatment? YES NO

If so, what type?

CHEMOTHERAPY RADIATION HORMONE OTHER _____

Have you completed treatment? YES NOIf so, when_____

In which therapy are you interested? (Please select only**ONE**)

MASSAGE THERAPY **REIKI THERAPY** **HEALING TOUCH**

ACUPUNCTURE **YOGA THERAPY**

***GUIDED MEDITATION** ***THERAPEUTIC MEDITATION & RELAXATION**

(* = Virtual Therapy available over Zoom, phone, etc.)

Tell us why you are interested in this program (please feelfree to continue on back of form if needed): _____

_____

_____

_____

_____

_____

_____

_____

Please return your completed application to…

*Mail:*CancerConnects • P.O. Box 2010 • East Syracuse, NY 13057

Email: cancerconnects@gmail.com

Disclaimer: Awarding of vouchers subject to availability of funds