Email to M4CF

PRINT

BREATHESTRONG
MILES FOR CYSTIC FIBROSIS

Applicant's Name:
Applicant's DOB:
Applicant's chosen activity:

CF Medical Provider Verification
MFCF BreathStrong Grant- Request for Information

Doctor's Name:
CF Care Center:
Center Mailing Address:
City, State, Zip code:

CF Care Center Point of Contact:
Phone:
E-mail (required):

Dear CF Care Provider,
We have received an application from the applicant listed above for a BreatheStrong grant from MFCF. Part of our application review process is to verify with their CF care provider their current health status.

The information we would like from you:

1. How long have you treated this patient?
2. How would you rate their compliance with medications and treatments on a scale of 1-10 (10 being 100% compliant.)
   ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10
3. Do you endorse their participation in the activity listed above as potentially beneficial to their health?
   ◯ Yes ◯ No ◯ With condition:
4. Do you have any concerns about their participation in these activities?

As the primary CF care provider for the patient listed above, I support and encourage their participation in physical activity as a part of their well-being. I understand that MFCF is not promoting any form of interaction between CF patients, and the funds being applied for are strictly for individual purposes of promoting recreation as an additive measure of airway clearance. I feel that he/she is an excellent candidate to receive a BreatheStrong Grant through MFCF.

Medical Provider Signature

Printed Name