LUNG CANCER INITIATIVE
of North Carolina

4000 Blue Ridge Rd. Suite 170
Raleigh, NC 27612
(919) 784-0410
(919) 784-0416 (Fax)

Patient Access to Care
Gas Card Application- Returning Applicants

Name of Applicant:_____ Date:_____

Address:_____ Date of Birth:_____

_____ Already received a gas card: Yes/No

Phone Number:_____ If yes, approx. date:_____

Email address (required):_____

(Please answer the following questions by checking the boxes with an X or √)

1.) Have you had any changes in your financial status?	□ Yes	□ No
If yes, please explain:		
2.) Have you had any changes in your working status?	□ Yes	□ No
If yes, please explain:		

If you have had any other changes since your last gas card, please explain (including treatment plan):

_____

_____

How has the Lung Cancer Initiative Access to Care Gas Card program impacted your life and treatment? _____

_____

_____

Name of the facility where treatment will be received:_____

Healthcare Facility Contact Person: _____

Contact Person email address:_____

Signature of Patient:_____

Signature of Contact from Healthcare Facility:_____