PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016-4416
Phone: (602) 255-5575 Fax: (602) 296-2371

ATTENDING PHYSICIAN STATEMENT

(Completed by Physician)

PRINT Name of Patient	**Patient SSN**	**Date Cancer First Diagnosed (MM/DD/YYYY)**
Has patient ever been previously treated for this condition or related condition? If Yes, provide the date and diagnosis of prior advice and treatment below:		❒ **Yes** OR ❒ **No**
Type of Cancer:		
Is this Skin Cancer?		

PRINT Name of Physician	
Address, City State & ZIP	
REQUIRED Signature of Physician	**Date (MM/DD/YYYY)**

PHYSICIAN INSTRUCTIONS

- **REQUIRED:** A copy of the ***Pathology Report***, confirming the diagnosis, must be included with submission of this document.
- If applicable, please complete the ***List of All Prescribed Medication*** form to indicate the prescriptions the patient has been or will be prescribed for the treatment of their cancer. We will also accept a formal printout from your office outlining the medications prescribed for the treatment of the patient's cancer only.