Pediatric Spine Foundation
Application

For families seeking assistance, who otherwise can't afford the expenses, with travel costs so that they may be able to consult with a surgeon who will provide treatment options for their child with scoliosis.

Today's Date: 9/1/2015

Patient Name (Last, First): _____ DOB:_____

Parent/Legal Guardian (Last, First):_____

Address:_____
(Street)

City/State:_____ Zip code:_____

Telephone:_____ Email:_____

Preferred Method to Contact:_____ Best Time to Contact:_____

Parent/Legal Guardian (Last, First):_____

Address:_____
(Street)

City/State:_____ Zip code:_____

Telephone:_____ Email:_____

Preferred Method to Contact:_____ Best Time to Contact:_____

Annual Household Income:$_____ Number of People in Household:_____
(We may require a copy of IRS Form 1040)

Have you contacted other charitable organizations:_____

If yes, which ones:_____

_____

Pediatric Orthopedic Surgeon and Appointment Information

Physician Name (Last, First):_____ Telephone:_____

Address:_____
(Street)

City/State:_____ Zip code:_____

Date of Appointment:_____

Or if Scheduled for Pediatric Orthopedic Spinal Surgery:

Surgeon Name (Last, First):_____ Telephone:_____

Address:_____
(Street)

City/State:_____ Zip code:_____

Name of Hospital:_____

Address:_____
(Street)

City/State:_____ Zip code:_____

Date of Procedure:_____ Type of Procedure:_____

Attach:

Summarized history including diagnosis, treatments, etc and copy of most recent spine x-ray

Transportation Information

How are you planning to get to your appointment:_____

Cost of Tickets:_____

How many people are traveling:_____

Have you purchased your tickets:_____

Please provide copies of your tickets along with any receipts.

Statement of Understanding and Authorization

I guarantee that all information given in this grant application is accurate. I allow the Pediatric Spine Foundation to discuss and share medical information provided with Foundation reviewers and referral sources.

Parent or legal guardian please print and sign your name for your child giving consent.

Name of Applicant:_____
(PRINT NAME)

Parent Name of Applicant:_____
(SIGN NAME) (DATE)

Parent Name of Applicant:_____
(PRINT NAME) (DATE)

Please mail application and requested documentation to the following address:

Pediatric Spine Foundation
PO Box 923
New York, NY 10163

Or scan and send the information to the following email address:
pediatricspinefoundation@gmail.com

Please note additional information may be required. Thank you.