HAWAII CHILDREN'S CANCER FOUNDATION

1814 Liliha Street Honolulu, Hawaii 96817
Direct Line: 528-5161 / Fax: 521-4689 / Email: info@hccf.org
To Call Toll-Free (Neighbor Islands): 1-866-443-HCCF
www.hccf.org

Book Reimbursement Application

Personal Information

Name: (Last, First, Middle Initial)	Age:
Present Address:	Telephone Number:
City, State and Zip Code:	Date of Birth:
Have you Ever Lived in Hawaii: Yes ☐ No ☐	Years Lived in Hawaii:

Education:

College/University or Vocational School	Year/Term Accepted

Medical History:

What Type of Cancer Did You Have?	Year of Diagnosis
Signature of Physician Confirming Medical History:	

Signature Date Print Physician Name Telephone #

Signature:

I certify that the information provided above is accurate.

Applicant Signature Date

HCCF Approval:

Signature Date Signature Date