Shaman's Reach Inc.

Physician Guided Terminal Illness Assistance Program Application

Patient Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Illness: _____

Primary Physician Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Required Documents Checklist

- Completed Physician Guided Terminal Illness Assistance Program Application
- Completed Terms and Conditions Document signed by both the applicant and his or her primary physician
- Completed Release of Liability Document
- Completed Wellbeing Survey (Completed at least once per month before receiving product)
- A copy of your medical records pertaining to your terminal illness

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

I understand that false or misleading information in my application or interview may result in my disqualification.

Shaman's Reach Inc. reserves the right to limit the number of participants in this study at its own discretion. However, we will, in good faith, help as many participants as we can.

Signature: _____ Date: _____