#  P.O. Box 4135Road Town, Tortola VG1110Virgin Islands



 Tel: 282-499-0022 E-mail: bvicancersociety@gmail.com

| Request for Financial Assistance Application |
| --- |
| **Applicant Information** |
| Name: |
| Date of birth: | SSN: | Phone: |
| Gender: □Male □ Female | Marital Status: □Married □ingle □Divorced □Separated |
| Nationality (Passport): | Place of Birth: |
| BVI Status: □Belonger □Resident Card □Work Permit □Non-Belonger (Work Permit exempted ) |
| Physical address: |
| City: | Island: | ZIP Code: |
| □Own □Rent  | Monthly rent/Mortgage: |  |
| Mailing address: |
| City: | Island: | District: |
| E-mail: |
| **PLEASE ATTACH A COPY OF A PHOTO IDENTIFICTION****(Passport, Belonger Card, Driver’s License, Work Permit card, etc.** |
| Please attached a copy of a photo identifaction ( PA |
| **Employment Information** |
| Employer: |
| Employer address: | How long? |
| Phone: | E-mail: | Fax: |
| City: | Island: | ZIP Code: |
| Position: | □Hourly □Salary | Annual income: |
| **Medical information** |
| Type of Cancer Diagnosed : |
| Date of Diagnosed:  | Doctor’s Name: |
| Health Institution:  |
| Tel: | Referred by: |
| **Insurance** |
| Do you have medical insurance: □Yes □No |
| Name of Insurance: |
| **IMPORTANT** |
| Your personal information will be kept in the strictest confidence. We will not contact your insurance company or your employer. We will not discriminate based on nationality, race, age or gender. |
| Signature of applicant | Date |
| **OFFICIAL USE ONLY** |
| Approved By |  |
| Cheque No. | Date |
| Received By: |  |
| Date: |  |