



550 Lobdell Ave. Baton Rouge, LA 70806
Tel: 927-2273, 1-800-883-4515, Fax: 928-8448

CANDLELIGHTER APPLICATION/GRANT APPLICATION

Patient's last name: _____ First name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Parish: _____ Phone(s): _____ (h) _____ (w) _____

Date of birth: _____ Sex: _____

Parents names: _____

E-mail address(es): _____

Emergency contact person: _____ Phone #s _____

Siblings names: _____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____

Type of cancer: _____ Date of Diagnosis _____

Doctor: _____ Hospital _____

Treatment plan: _____

Would you be interested in applying for a one-time \$500.00 Candlelighter Grant?

_____ Yes _____ No

Please be aware applicants must meet financial eligibility guidelines to qualify for a Candlelighter Grant.

Release statement: The above applicant and his or her siblings have permission to participate in our activities and field trips and to appear in photographs and on TV for publicity purposes. In the event that neither parent or guardian can be reached, nor the emergency contact person, I give my permission to hospitalize and secure proper treatment for my children. I hereby release Cancer Services of Greater Baton Rouge from any liability associated with any Cancer Services activities.

Signature of Parent or Guardian _____ Date _____