Applicant's Name: ______________________________ ______________________________

(First Name) (Last Name)

Dream Request: ____

Alternative Dream Request (Must be entirely unrelated to first dream): ______________________________
(If no alternative dream is listed, only primary dream request will be pursued)

Participants requested family, spouse, caregiver and children under the age of 18 living at home:

PARTICIPANT/CHILD'S NAME:	SEX:	RELATIONSHIP:	AGE:	DOB:

Step 4 - Medical Information:

Dream Applicant's Signature: ____

This Part To Be Completed By Physician Only

Physician's Name: ____

Physician's Address: ____
(Including City/State/Zip)

Phone Number: (_____)______________________ Fax Number: (______)______________________

If patient is under hospice care - Hospice Name: ______________________ Phone: (_____)______________
(A Hospice Application that is more expedited is available for social worker to fill out on our website at www.dreamfoundation.org)

Applicant's Diagnosis: ____

Current Life Expectancy in MONTHS: ______________________

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient **has a life expectancy of twelve months or less** OR my patient could not actively participate in the requested dream beyond the next twelve months. I certify that my patient is of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the dream request with my patient and have deemed it safe and reasonable if his/her dream is granted within the next three months.

______________________________ ______________________ ______________________
Signature of Physician, NP or PA only **Title** **Date**