Complementary Therapy Voucher Application (Jan 2024)

Name: _____ Date of Birth: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

What is your cancer diagnosis?:_____

When were you diagnosed?: _____

Name of oncologist: _____

Are you currently undergoing treatment? ☐ YES ☐ NO

If so, what type?

CHEMOTHERAPY RADIATION HORMONE OTHER _____

Have you completed treatment? ☐ YES ☐ NO If so, when _____

In which therapy are you interested? (Please select only **ONE**)

MASSAGE THERAPY **REIKI THERAPY** **HEALING TOUCH**

FOOT REFLEXOLOGY **ACUPUNCTURE** **YOGA THERAPY**

***GUIDED MEDITATION** ***THERAPEUTIC MEDITATION & RELAXATION**

(* = Virtual Therapy available over Zoom, phone, etc.)

Tell us why you are interested in this program (please feel free to continue on back of form if needed): _____

_____

_____

_____

How did you hear about our Complementary Therapy Program? _____

_____

Please return your completed application to…

Mail: CancerConnects • P.O. Box 2010 • East Syracuse, NY 13057

Email: officecancerconnects@gmail.com

Questions: (315) 634-5004

Disclaimer: Awarding of vouchers subject to availability of funds