



Complementary Therapy Voucher Application (Feb 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