DANIEL
DANIEL McLELLAN
MEMORIAL FUND

HELPING CHILDREN WITH LEUKEMIA

REQUEST FOR FINANCIAL ASSISTANCE

This Fund has been made available to pediatric oncology patients of the IWK Health Care Centre and the Janeway Children's Hospital in memory of Daniel McLellan. Patients must meet three of the following criteria to qualify:

- ***An active Patient of the IWK or Janeway Hospital(s).***
- ***Traveling outside the Atlantic Provinces to achieve Bone Marrow/Stem Cell Transplant, and or returning from transplant.***
- ***Away from home for an extended period receiving treatment.***
- ***Recommended by Patient's Social or Case Worker on the bases of financial need***

Childs Name: _____ **Date of Birth:** _____
LAST NAME FIRST NAME MONTH/DAY/YEAR

Guardian(s) Name: _____ **Relationship:** _____
LAST NAME FIRST NAME

_____ **Relationship:** _____
LAST NAME FIRST NAME

Social Worker(s) Name: _____ **Contact Number:** _____

Name of who donation is payable: _____
LAST NAME FIRST NAME

Address for donation to be mailed: _____

_____

*****All information disclosed is held in strict confidence and used only for the purpose of providing financial assistance. Under no circumstance is patient or family information shared with other sources for any purpose. *****

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