



Applicant's Name:

Applicant's DOB:

Applicant's Chosen Activity:

CF Medical Provider Verification **M4CF BreathStrong Grant: Request for Information**

Doctor's Name:

CF Care Center:

Center Mailing Address:

City, State, Zip Code:

CF Care Center Point of Contact:

Phone:

Email (Required):

Dear CF Care Provider,

We have received an application from the applicant listed above for a BreatheStrong grant from M4CF. Part of our application review process is to verify with their CF care provider their current health status.

The information we would like from you:

1. How long have you treated this patient?
2. How would you rate their compliance with medications and treatments on a scale of 1-10.
(10 being 100% compliant.) Circle one: 1 2 3 4 5 6 7 8 9 10
3. Do you endorse their participation in the activity listed above as potentially beneficial to their health?
4. Do you have any concerns about their participation in these activities?

As the primary CF care provider for the patient listed above, I support and encourage their participation in physical activity as a part of their well-being. I understand that M4CF is not promoting any form of interaction between CF patients, and the funds being applied for are strictly for individual purposes of promoting recreation as an additive measure of airway clearance. I feel that he/she is an excellent candidate to receive a BreatheStrong Grant through M4CF.

(Medical Provider Signature)



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CF Medical Provider Verification (Page 2)

M4CF BreathStrong Grant: FEV-1 Scores

Please list the applicant's FEV-1 scores from the last one to two years, we require a minimum of **at least 4 scores**. If the patient is too young, or unable to provide lung function scores, please explain:

Please enter FEV-1 data for the previous 12 months below, starting with the OLDEST and ending with the NEWEST scores. Please use two decimals for the "Score" column. *Minimum of four FEV-1 scores required.

*Score: _____ Percentile: _____ % Date: ___/___/___

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Additional Comments:

_____ (Medical Provider Signature)