

# Budda's Brotherhood Foundation Financial Assistance Request Form

## Instructions:

- Complete Section A (Firefighter Information)
- Have your doctor complete and sign Section B: Physicians Statement of Disability
- Have your Employer complete and sign Section C: Employer's Statement of Disability
- Make sure to sign your claim form
- **Mail request to: info@buddabrotherhood.org or  
Budda's Brotherhood Foundation  
P.O. Box 1178  
Batavia, IL 60510**

**Facebook page: Budda's Brotherhood Foundation**

## Section A: Firefighter Information

Last Name	First Name	Middle
Phone Number		
Mailing Address		
City	State	Zip
Place of Employment		
Mailing Address of Employer		
City	State	Zip
Employer Phone Number		
Name of Fire Chief		
Date Diagnosed with Cancer		
Cancer Type:		

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Section B: Physician Statement of Disability

Physicians Name		
Phone Number	Fax Number	
Mailing Address		
City	State	Zip
Hospital Name		Phone Number
Mailing Address		
City	State	Zip

Date of initial cancer diagnosis: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Currently undergoing treatment?    Yes        No

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Patient signature authorizes physician to release this information to Budda's Brotherhood Foundation

# Section C: Employer Statement of Disability

Name of individual needing assistance \_\_\_\_\_

Employer's Name		
Phone Number	Fax Number	
Mailing Address		
City	State	Zip
Fire Chief's Name		

Date of Hire                    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Is employee still employed?      Yes      No

Has employee returned to work?    Yes      No

\_\_\_\_\_  
Signature of Fire Chief

\_\_\_\_\_  
Date