



Applicant's Name: \_\_\_\_\_  
(First Name) (Last Name)

**Dream Request:** \_\_\_\_\_

**Alternative Dream Request: (Must be entirely unrelated to first dream):** \_\_\_\_\_  
(If no alternative dream is listed, only primary dream request will be pursued)

#### **Step 4 - Medical Information:**

Dream Applicant's Signature: \_\_\_\_\_

#### **This Part To Be Filled Out By Physician Only**

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
(Including City/State/Zip)

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

If patient is under hospice care - Hospice Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
(A Hospice Application that is more expedited is available for social worker to fill out on our website at [www.dreamfoundation.org](http://www.dreamfoundation.org))

**Applicant's Diagnosis:** \_\_\_\_\_

**Current Life Expectancy in MONTHS:** \_\_\_\_\_

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient **has a life expectancy of twelve months or less**, of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the dream request with my patient and have deemed it safe and reasonable if his/her dream is granted within the next three months.

**Physician Signature Only**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_