



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)

Participants requested family, spouse, caregiver and children under the age of 18 living at home:

PARTICIPANT/CHILD'S NAME:	SEX:	RELATIONSHIP:	AGE:	DOB:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### Step 4 - Medical Information:

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

### This Part To Be Completed 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 nine months or less** OR my patient could not actively participate in the requested dream beyond the next nine months. I certify that my patient is 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.

\_\_\_\_\_  
Signature of Physician, NP or PA only Title Date