RECIPIENT APPLICATION AND MEDICAL VERIFICATION

Recipient Name (First, Middle Initial, Last): _____

Address: _____

City/State/Zip: _____

Phone Number (H): _____ (W): _____ (C): _____

Email: _____

TERMS:

AngelHair, Inc. reserves the right to provide no more than (1) wig per Recipient within a 5 year period. Wig care and product purchases are the full responsibility of the Recipient and AngelHair, Inc. is not responsible or liable for damages caused by third party support services. Carolyn Anderson Premier Salon & Wig Studio may provide additional services as needed or requested at the sole financial responsibility of Recipient. All applicants will be provided a quality synthetic wig of their choice at no cost. Human hair wig requests fall outside of the no cost wig program, however; AngelHair, Inc. donates/stipends $500 towards human hair wig selections and associated costs. Customization services can only be provided to in person applicants. AngelHair, Inc. non-profit wigs and services are open to United States citizens only.

I have read, understand and agree to the terms of this application:

Recipient Signature: _____ Date: _____

MEDICAL VERIFICATION

- **This application and verification must be faxed with the clinic/hospital cover sheet from the physician's/provider's office directly to AngelHair, Inc. at 1-844-891-1384.**
- **A current copy of a United States Government issued photo I.D. is required to be faxed with this application.**

Clinic/Hospital: _____

Physician: _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

PLEASE SELECT ONE:

☐ The above named Recipient will be suffering hair loss due to cancer drugs and/or treatments.

☐ The above named Recipient has suffered hair loss within the past 6 months due to cancer drugs and/or treatments.

☐ The above named Recipient has suffered hair loss within the past year and is currently suffering alopecia directly and specifically from cancer related radiation and chemotherapy treatments, and, for this reason, is being referred to AngelHair, Inc.

This referral covers the application process for the above named Recipient.

Physician Signature: _____ NPI #: _____

****Any written or typed modification to this Application/Verification voids this application in its entirety.*

AngelHair, Inc.'s Mission: To support the healing powers of appearance while respecting each person's dignity and privacy during all services. To provide 100% no cost synthetic wigs to women suffering hair loss due to cancer drugs and/or treatments.

Fax 1-844-891-1384 Executive Director (952) 476-2125 angelhairorg@gmail.com

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