Gulf Breeze First Responders Crisis Fund

Attachment A: To be completed by a healthcare provider if applying for a catastrophic illness or injury.

Physicians: Email completed form to Community Foundation of Northwest Florida at info@cfnwf.org
-or-
Applicants: Upload completed form to GBFRCF Application at www.cfnwf.org/gbfrcf

To the Attending Physician:
The employee below has applied for crisis funding from the Gulf Breeze First Responders Crisis Fund for his/herself or the patient named below. This form is required by your patient to be considered for a grant.

Physician Information : First Name // Last Name:_____

Address: _____

Telephone: _____ // Email: _____

Gulf Breeze First Responder Information: First Name // Last Name: _____

Name of Patient: _____Relationship to Employee:_____

Patient Address: _____

Does the named patient have a catastrophic injury or illness? Yes_____ No _____
Note: Catastrophic injury or illness is defined as a serious injury, impairment, or physical condition that a licensed physician certifies as critical, life threatening, or terminal.

Date of illness or injury: _____Probable duration of illness or injury: _____

Describe the catastrophic illness or injury using appropriate medical facts within your knowledge (attach supplemental documentation if necessary).

_____

_____

_____

_____

Does the patient need constant care? Please circle one. Yes_____ No _____
If yes, what is the estimated amount of time that the patient will need this care? _____

Signature of Healthcare Provider: _____Date: _____