

**(Insert Letterhead)**

**PHYSICIAN LETTER  
CERTIFICATION OF DIAGNOSIS FOR MARYLAND CANCER FUND**

Date

Physician's Full Name  
Address  
Specialty  
Medical License Number

Dear Maryland Cancer Fund Coordinator:

This letter is to certify that \_\_\_\_\_,  
(Patient Name)

has been diagnosed with \_\_\_\_\_, on \_\_\_\_\_.  
(Type of Cancer) (Date of Diagnosis)

**OR**

is being treated for \_\_\_\_\_, and began treatment on \_\_\_\_\_.  
(Type of Cancer) (Date of Treatment)

**OR**

has a finding suggestive of \_\_\_\_\_ as of \_\_\_\_\_ and needs  
(Type of Cancer) (Date of Finding)  
to obtain a cancer diagnosis.

**SPECIAL NOTES** (e.g., recurrence of cancer, inability to complete treatment within Maryland Cancer Fund grant award timeframe):

Sincerely,

Physician's Signature