The Tracy Sollis Leukaemia Trust

Grant Application Form

(Registered charity number 1069269)

Completed forms should be returned to info@tracysollistrust.org or sent to:

The Tracy Sollis Leukaemia Trust, 7 Library Arcade, Evesham, WR11 4HG

Patient Details

This section must be completed by the patient or their representative i.e.parent/guardian.

Title		**First Name**		**Surname**	

Date of Birth		**Address**	

Postcode		**Phone**	

Email	

Data Consent

Please sign below to give The Tracy Sollis Leukaemia Trust consent to use your data solely in support of this application. A representative can sign on behalf of the patient if they have power of attorney, parental responsibility or are the patient's legal guardian.

Signature	
Date	
Capacity** ***(if not patient)	

Bank Details (to be used if your application is successful)

Name of Account Holder			
Account Number		**Sort Code**	

** We cannot process your application without this information.*

Explaining Your Specific Need

Please explain specific needs that have arisen from or are related to your leukaemia diagnosis. Please list in order of priority as it may not be possible to assist with all of the items requested. Please note that the normal amount granted is £600.

Claim example e.g. hospital travel, extra heating expenses incurred.

Please tell us the impact this money would mean to you

Professional Signature

Date of Diagnosis		
Name and Address of G.P		
Name of Hospital and Consultant		
*	**Doctor Signature**	
	or Consultant Signature	
	or C.N.S Signature	

**one professional signature required.*

Patient Confirmation

I confirm that I am

[the patient] [the patient's representative]

and that the information provided is correct and accurate. **delete as appropriate*

Sign Name	
Print Name	
Date	

Office Use Only

Date received	
Application number	
Date of Panel	
Date of follow up	
Amount requested	
Amount awarded	