**Physician Letter Certification of Diagnosis**

**Letterhead**

Physician’s Full Name Address

Specialty

Medical License Number

Date

Dear Maryland Cancer Fund Coordinator:

This letter is to certify that has been

Patient Name

* diagnosed with **, on** or

Type of Cancer Date of Diagnosis

* is being treated for , and began treatment on

Type of Cancer

 , or

Date Treatment began

* Has finding suggestive of and needs to obtain a cancer diagnosis.

Type of Cancer

Sincerely, Physician’s Signature