An Elderly Wish Foundation - Wish Request Form

HOW TO REQUEST A WISH

To help make your wish come true, we need a few things to get started. We ask that you take the following steps:

- Step 1: Write a paragraph explaining your wish.
- Step 2: Complete the Request Form.
- Step 3: Have your physician or medical care provider complete the Physician Statement.
- Step 4: Include a photo of yourself, if available.

Use the attached forms. The Board of Directors will verify your eligibility, contact you with any questions, and get started on your wish once it has been approved.

Once you have completed these four steps, send the completed application to:

An Elderly Wish Foundation
"Making Wishes Come True"
P.O. Box 4365,
Antioch, CA 94531-4365

Email info@elderlywish.org
Telephone (925) 978-1883
FAX (925) 978-1884

WISH REQUEST LETTER OR FAX

As part of your wish request, we ask that you send us a personal note, written by you, or a close family member, describing your wish, why you need our help, and the importance or significance of the wish to you. We want you to tell us WHY this wish matters to you, and HOW this wish will provide you with a greater sense of comfort and fulfillment. Your letter or fax should:

- Refer to the illness you are battling
- Clearly describe what your special wish is
- If your wish involves air travel, include the airport of departure and desired dates for travel

Unfortunately, we cannot grant the following types of wishes:

- Requests for cash, automobiles, or property;
- Requests for foreign travel or visas
- Requests to pay for medical treatments or legal assistance

WISH REQUEST FORM

Please write legibly in ink.

Recipient's Name _____

Address _____

City _____State _____Zip _____

Phone (___) _____

Email _____

Age _____ DOB _____

Referred by _____

I give permission to An Elderly Wish Foundation to contact my physician for verification of my illness on behalf of my wish.

Signature _____Date _____

Nearest Relative/Contact _____

Relationship _____

Address _____

City _____ State_____ Zip _____

Phone (___) _____

Email_____

PHYSICIAN'S STATEMENT OF ELIGIBILITY

I certify that I am the Applicants Primary Physician or Medical Care Provider. I give permission to AEWF for a wish to be granted to the patient named below. I understand that to be eligible for a wish the recipient must be 50 years or older and have been diagnosed with a serious or chronic illness.

Recipient's Name _____

Diagnosis_____

Is oxygen required? YES / NO

Physician or Medical Care Provider's Name:_____

Address _____

City_____State_____Zip_____

Phone (___) _____

Email_____

Signature_____Date_____