Lisa's Army is a non-profit organization whose goal is to fulfill Lisa Loonstyn-Golden's request to provide comfort to courageous individuals presently battling cancer. We accomplish this by providing our signature Comfort Care Packages free to men, women and children currently undergoing cancer treatment.

As care providers, you have direct insight into the daily challenges and struggles your patients endure; you know them best. Our packages are filled with comforting, uplifting, and useful items to help encourage and inspire someone going through treatment.

Do you know someone going through treatment who may benefit from a Comfort Care Package? We would like to help!

Please complete this form along with the approval signature from the nominee's doctor, nurse navigator or social worker. Due to the high volume of nominations we will use a lottery system for those who come from outside of our region. Upon receipt, the form will be processed and if selected, the process will begin. It may take 4-8 weeks to complete the process.

Nomination forms can be submitted by mail, fax or email:

Mailing Address: Lisa's Army, 8945 Ridge Avenue, Unit 8, Philadelphia, PA 19128

Fax Number: (215) 403-7108

E-Mail: Please scan the documents and email to info@lisasarmy.org.

OFFICE USE

RECIPIENT #_____

CCP #_____

LISA'S ARMY

Comforting Those Battling Cancer

Comfort Care Package Nomination Form

Nominee's Name: _____

Type of Cancer: _____

Treatment Start Date: _____ How long is treatment_____

DOB: _____ Male or Female _____ Today's Date: _____

Nominee email: _____

If minor provide a parent or guardian email: _____

Care Center where treatment is: _____

Please provide name of any other facility that nominee has been previously treated.

_____

Please **circle one item** your nominee would benefit from:

iPad Beats Headphones

Please provide the address where the Comfort Care Package is to be delivered. Package will have to be signed for.

Name: _____

Street Address: _____

City_____State_____Zip_____

LISA'S ARMY
Comforting Those Battling Cancer

Comfort Care Package Nomination Form

Requestor's Information:

Your Name: _____

Your Contact Number: _____

Your Email Address: _____

Your Relationship/Role to the Nominee: _____

How did you hear about Lisa's Army? _____

_____

Requestor's Signature Print Date

Medical Contact Information: PLEASE PRINT CLEARLY

Doctor, Nurse Navigator or Social Worker Name:

_____

Address: _____

Contact Number:_____

Email Address:_____

_____

Medical Contact Signature Print

MEDIA RELEASE/CONSENT FORM

MEDIA RELEASE/CONSENT: *(Required)*

Lisa's Army donors LOVE to see how we help. When we share our stories, it increases donor awareness and encourages contributions when they see how their donations are making an impact. Oftentimes, this is done through our social media presence, online website (**www.LisasArmy.org**), or digital and print publications including, but not limited to, donor newsletters, posters, pamphlets, and advertisements. When these moments arise, it is important that Lisa's Army know how to proceed with the individual identified below.

☐ **YES**. I grant Lisa's Army full permission to release, disseminate, reproduce, publish, or use any resulting words, recordings, and/or images of *(Name)* _____ or any other identifying information, including the identified individual's full name, images or likeness, diagnosis, or treatment center, in any manner it sees fit, including in any promotional, informational, or educational materials online, on film or photographs, or in print, including digital print media, for the purpose of promoting Lisa's Army, its programs, initiatives, and fundraising efforts. By checking this box, I waive the right to inspect any product containing the identified individual's name and/or photo prior to publishing. I also waive the right to hold Lisa's Army responsible for the usage of the identified individual's photo, name, or likeness. I understand that there will be no compensation associated with the use of the identified individual's photo and/or name.

☐ **NO**. I do not wish to have *(Name)* _____'s photo or name used for any promotional materials by Lisa's Army for any purpose.

_____ _____

Signature of the Identified Individual **Date**

_____ _____

Name of Parent/Guardian (if Under 18) **Date**

_____ _____

Name of Parent/Guardian (if Under 18) **Date**

PARTICIPATION AGREEMENT

_____, the child's _____ is requesting
(Parent/Guardian's Name) (Relationship)

to receive services from Lisa's Army for _____.
(Patient's Name)

By signing below, you are confirming with your signature that you have read and understand our eligibility requirements, and you are confirming that your child meets these requirements. You are giving permission for medical professionals/social workers/child life specialists to confirm medical information about your child, in addition to discussing ideas for how Lisa's Army will provide resources/activities to your child.

In exchange for the Lisa's Army's consideration of your child's application and the resources that it will provide if they are selected, I agree to release Lisa's Army, its employees, volunteers, and trustees from and against any and all liability, damages, and claims that arise, regardless of the reason they occur or the grounds on which they are based, in connection with Lisa's Army's consideration of my child's application and any resources that it provides, from this time forward.

I intend this release to be binding on their heirs, assigns, and anyone else who may now or in the future bring a cause of action or make a claim on their behalf.

_____ _____

(Parent/Guardian's Signature) **Date**