



APPLICATION FOR TRANSPORTATION ASSISTANCE

PERSONAL INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

____ MARRIED ____ SINGLE ____ DIVORCED ____ WIDOWED

NUMBER OF CHILDREN LIVING WITH YOU: _____ CURRENTLY WORKING ____ YES ____ NO

____ FULL-TIME ____ PART-TIME ____ RETIRED ____ DISABLED ____ LAID OFF ____ STUDENT

DIAGNOSES:

____ UTERINE/ENDOMETRIAL ____ FALLOPIAN ____ CERVICAL ____ VAGINAL/VULVAR

DATE DIAGNOSED: _____ STAGE: _____ RECURRENCE _____

PHYSICIAN/ONCOLOGIST: _____ DOB: ____/____/____

ARE YOU CURRENTLY RECEIVING TREATMENTS? ____ YES ____ NO ____ SOON

YOU HAVE MY PERMISSION TO CONTACT MY PHYSICIAN TO VERIFY DIAGNOSIS - PLEASE INITIAL _____

SIGNATURE: _____ **DATE:** _____

Your application will remain confidential. **A note from your physician or Social Services stating you are currently in treatment for cancer is required.** Gift cards for gasoline will be issued if you qualify. Questions can be directed to 419-866-6622. Please mail your application to the OCC 5577 Airport Hwy. Ste. 206 Toledo, Ohio 43615

OCC contact information: 419-866-6622

We're sorry but until all women in NW Ohio & SE Michigan have their needs met, we are unable to assist those outsidess of our area.