



**FOR OFFICE USE ONLY**

- VH
- VF
- H
- NTB
- P (hnw)

# COOLING PROGRAM

## QUALIFICATION APPLICATION

*(Please Print)*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

When were you diagnosed with MS? \_\_\_\_\_ Current major symptoms: \_\_\_\_\_

Do you or your spouse have medical insurance?  Medicare  Medicaid  Private carrier

Monthly gross income \$ \_\_\_\_\_ Monthly expenses \$ \_\_\_\_\_ Disposable income \$ \_\_\_\_\_

***Choose One Option Only:***

\_\_\_ **Full Vest:** Size  L  XL - Color  Navy  Tan

\_\_\_ **Sports Package:** (half vest, hat, necktie, wristbands) Blue only.

Size  M  L  XL  XXL

\_\_\_ **Accessory Package:** (hat, necktie, wristbands)

Hat: Size  L  XL - Color  Navy  Khaki

I hereby release and hold the Multiple Sclerosis Foundation, Inc. harmless from, against, and in respect of all claims, injuries, actions, demands, suits, losses, liability or other damages that may be incurred as a result of accepting goods or services.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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