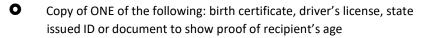


APPLICATION FOR HAIR REPLACEMENT

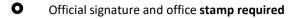
Hair To Help House L508 Haji Limo Goth Gulshan-e-iqbal block 3 Karachi Phone : (021) 36405006 03313098333 Email : hairtohelppakistan@gmail.com

Before sending this application, please ensure that <u>all</u> information is completed and that all of the following documents are enclosed. Otherwise, the application will not be approved.

O Section 1: Patient Information



- Section 2: Medical Information
- Section 3: Referral Information



- Prescription for a cranial prosthesis (wig)
- O Section 4: Hair To Help and cranial prosthesis (wig) Receiver agreement



SECTION ONE: PATIENT INFORMATION

how did you hear about Hair To Help?

Patient Name:				
Age:	Date of birth://			
Guardian(s) Name(s) (if the patie	ent is under 18)			
Address:				
City:	State/Province:	Zip or Postal Code:		
Country:				
Email Address:				
Telephone: ()				
School/Grade:				
Are you a past recipient? •	Yes O No Date of last a	application submitted://		
SECTION TWO: MEDICAL Reason for hair loss: Please state illness/medical co Have you already experienced Are you undergoing medical t If yes, what type of treatment? Are you currently or will you If so, for how long?	ndition: hair loss? ••• Yes •• No reatment? •• Yes •• No 2 soon be admitted to the hosp			
Name of Physician:				
Hospital/Office address:				
Do you have a prescription for	r a cranial prosthesis?	O Yes ONo		

Hair To Help L508 HaJi limo goth gulshan-e-iqbal block 3 Karachi – P: (021) 36405006 www.pyf.org.pk

"Helping children look themselves and live their lives."



SECTION 3: REFERRAL INFORMATION (must be completed in entirety)

Name of Hospital /Or	rganization:		
Telephone: ()	Emai	I Address:	
Please circle one:	• Doctor • Nurse • Soci	al Worker • other	
Address:			
	State/Province:		
Are you the primary	contact for this recipient?	O Yes O No	
2) This family	medical need of this patient for t y would otherwise not be able to ive (Please write in capital):	afford payment of this pro	
	ntative:		
	• documentation from a medica ed. Please attach to application	•	iption, doctor's Stamp Place Here



SECTION 4 : Hair To Help and cranial prosthesis (wig) Receiver agreement

As you know, Hair To Help covers the costs of these customized hairpieces, products, and consultation fees, but as a non-profit organization, we are constantly seeking funds to offset these costs. For each of our recipients, we create a story that focuses on her personality, interests, and personal story with hair loss and with Hair To Help. We value our recipients' privacy, and we do not disclose personal information such as last names, parents' names, addresses, or phone numbers. By signing below, you agree to help us to compile a story by sending us information about yourself, before and after photos, and a thank you letter after you receive your hairpiece.

I agree to participate in the "My Story".

T 7	
Y	
<u> </u>	

Applicant Signature

Date:

Х

Date: _____

Parent/Guardian Signature (if age below 18)