CHECKLIST FOR SPONSORING SHRINER

Patient Name:_____

Date:_____	YES	NO
Does this request fall within our mandate? (i.e. orthopedic, burn) **(If NO, DO NOT SUBMIT APPLICATION)**	_____	_____
Has the Referring Doctor Indicated Diagnosis?	_____	_____
Has the Referring Doctor's Signed the Application?	_____	_____
Has the Guardian Signed the Application?	_____	_____
Has the Family Provided All Necessary Medical Records?	_____	_____
Is the Family Requesting an Assessment at a Shrine Hospital?	_____	_____
If Yes, (Please Circle) Montreal, Boston or Philadelphia?		
If Boston or Philadelphia Have You Provided the Family With An American Application Form?	_____	_____
Is the Family Requesting Travel Assistance to the IWK?	_____	_____
Is the Family Requesting Assistance With the Purchase of:		
a) Braces?	_____	_____
b) Orthotics?	_____	_____
c) Jobst?	_____	_____
d) Other? (Please Describe)	_____	_____

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Requests outside the scope of our mandate will be referred back to the sponsoring Club for consideration. Incomplete Applications, will be returned to the Referring Shriner.

PLEASE INCLUDE THIS CHECKLIST WITH THE APPLICATION

Rev: June 2001