GRANT HENRIKSEN MEMORIAL FUND

Today's Date:					
Patient's Last Name:		First:		Middle:	
Type of Cancer:	Is Patient Still Continuing Treatment?	Was Surgery Required?	Birth Date:	Age: Sex:	
Date Diagnosed:	How Often Are You Commuting For Treatment?	Usual Lodging When Traveling Treatments: Hospital, Hotel, Friends/Family	How Far Do You Travel For Treatments?	Ages Of Siblings Living With You?	

Address:	Father: Email:	Mother: Email:
Street:	H Phone: Cell:	H Phone: Cell:
City:	Insurance:	Insurance:
State, Zip:	Employer:	Employer:

Primary Physician: Hospital: Phone: Fax:	Primary Oncologist: Hospital: Phone: Fax:

Person Completing Registration & Relationship If Other Than Physician or Parent:

ADDITIONAL INFORMATION OR COMMENTS

Send Registration To: The Grant Henriksen Memorial Fund, C/O Tracy Henriksen
117 Dandelion Lane
Marquette, MI 49855

Fax: (906) 225-0995
Email: Alwayscalltracy@gmail.com
Cell: (906) 250-0051