UNITED WE CARE UNITED WE SHARE

UNITED CANCER SUPPORT FOUNDATION

6700 Baum Drive Suite 8 Knoxville, TN • Phone: (865) 474-1551 • Email: info@unitedcsf.org

Colorectal Cancer Screening Application

PARTICIPANT INFORMATION

First Name:	Middle:	Last name:	
Birth date:_____/_____/_____	Age:	Gender:	Race:
Home address:	City:	State:	Zip code:
Phone No.:	E-mail:		
Household size: Household income: □ under 20k	□ 20k to 49,999	□ 50k to 74,999	□ 75k to 99,999 □ over 100k
Language spoken: If you have an interpreter, what is his/her name:		Contact number:	

SCREENING HISTORY

1. Have you done any types of colorectal cancer screening before?		1a. Date of last screening:	
2. What type of screening did you do?		2a. Were the findings:	Positive ☐ or Negative ☐
3. Do you have a primary doctor?		3a. If yes, what is your primary doctor's name?	
3b. Where is your doctor's office?		3c. What is your doctor's contact number?	

AGREEMENT

1. I hereby declare that the information provided in this form is true and correct.
2. I understand that all information submitted will be kept strictly confidential and to be used for statistical analysis and education purposes only.
3. I understand that UCSF will reserve the right for final decision of the application and to decline application without providing any explanation.

By Signing my name below, I acknowledge that I have read, understand, and agree to the policies listed above.

SIGNATURE

Signature		Date	