



MEDICAL TRAVEL ASSISTANCE

Request Form

Applicant Information

Name (Last)		(First)	(Middle Initial)
Address		City	
State	Zip code	Email Address	
D.O.B.		Mobile Phone	Home Phone

May CDBF provide you with updates and mailings? YES NO

Are you an adult applying on behalf of a minor? YES NO

Complete the section below if the applicant is a minor

Guardian's Name (Last)		(First)	(Middle Initial)
Relationship to Applicant		Email Address	Primary Phone

Do you authorize CDBF to publicize your child's photo? YES NO

Parent/Guardian Signature _____

Media Release (Optional)

I give permission to the Cody Dieruf Benefit Foundation [CDBF] to publicize my photographs, application responses, and other forms of communications for marketing and outreach purposes. I understand these purposes may include physical publications in print advertising, appeal letters, flyers, and/or brochures as well as digitally on our website and social media accounts.

Applicant/Guardian Signature _____

If you do **not** want to share your photographs and statements with CDBF for marketing and outreach purposes, do not sign the above release. We may still request photos and statements from you, but this content will not be publicized without express consent.

Travel Information

Destination Name	City	State
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Has this travel already occurred? YES NO

Did this travel require an overnight stay? YES NO

If yes, what was the length or estimated length of the stay? _____

Number of individuals who traveled (including the patient) _____

Relationship of all travelers to the individual with cystic fibrosis:

Briefly describe the medical reason for this travel:

Cost Breakdown

If the travel has already occurred, please attach copies of receipts for all listed expenses. Otherwise, you will be required to submit your receipts once you've acquired them.

Airline travel	\$ _____
Cost of fuel for automobiles	\$ _____
Other modes of travel	\$ _____
Hotel	\$ _____
Food	\$ _____
Childcare expenses incurred by travel	\$ _____
Miscellaneous associated expenses	\$ _____
Total Expense	\$ _____

Submit to the Cody Dieruf Benefit Foundation via email at pam@breathinisbelievin.org or via mail to PO BOX 7361, BOZEMAN, MT 59771.