



32 Strawberry Hill Court, Suite 11  
Stamford, CT 06902 USA  
(203) 276-5949

## Application for Care-Children Under 18

We look forward to considering your application. As you provide the information requested below, please note the request at the end of the application for a brief health history along with back-up documentation.

*Note, too, that to comply with U.S. government rules, only one family member or caregiver will be able to travel to the U.S. with your CF patient. In addition, both travelers must have a valid passport in order for your application to be considered. If you are accepted into the program and travel to the U.S. for care, we will collect your passports upon your arrival, and we will return them at the airport when you depart.*

Please understand that none of the information you share below will disqualify you from consideration as long as it is truthful and accurate. To comply with U.S. government rules, if we find any misleading statements or documentation in what you send, we will be permanently unable to consider your application.

**Please provide the following:**

Full legal name of individual with CF (as seen on passport):

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Your first and last name if you are the parent or caregiver: \_\_\_\_\_

Your Whatsapp number: \_\_\_\_\_

Your email address: \_\_\_\_\_

**For individual with CF:**

Date of birth: \_\_\_\_\_

Place of birth: \_\_\_\_\_

Complete home mailing address:

\_\_\_\_\_

\_\_\_\_\_

Email address, if applicable: \_\_\_\_\_

Whatsapp number, if applicable: \_\_\_\_\_

International airport nearest your home: \_\_\_\_\_

Description of daily medical treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Description of any diagnoses besides CF:

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Doctor's first and last name: \_\_\_\_\_

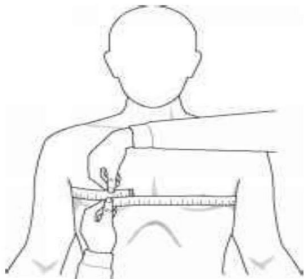
Doctor's Whatsapp number and email address: \_\_\_\_\_

Name and mailing address of hospital or CF clinic:

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Weight \_\_\_\_\_ Chest measurement as illustrated in the picture below \_\_\_\_\_



Does your household operate on 110 volts of electricity or 220 volts (circle one)?

**For parent or caregiver:**

Level of education, profession, and annual family income (*A reminder that honest income numbers will not be disqualifying, but inaccurate numbers will be*):

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Level of English fluency (circle one):      Fluent      Some English      No English

Ability to pay for airfare and housing in the U.S. (circle one):

I can pay full cost

I can pay partial cost

I am unable to pay

Name, relationship, and place of residence of any relatives you may have living in the U.S.:

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As mentioned above, for those who are accepted into the program for care in the U.S., we will collect your passports upon your arrival and keep them safe for you, and we will return them at the airport when you depart. Please sign to indicate your consent: \_\_\_\_\_

Three additional individuals who we may keep on file as contacts (please include name, Whatsapp number, and email address for each):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Please include the following with your application:**

- Photo of individual with CF and accompanying parent (for I.D. purposes)
- Proof of vaccination for individual with CF and accompanying parent
- A brief explanation for why you want to receive U.S.-based medical care
- A brief health summary written by your physician, translated into English
- The following health records:
  - 1) sweat test results
  - 2) stool elastase results
  - 3) results of any genetic testing
  - 4) blood work with vitamin levels

5) copy of a recent chest x-ray