



Angel Hair Foundation

2783 Suncrest Ave., Eugene, OR 97405
Phone: (541) 344-5135
Email: angelhairfoundation@yahoo.com
Web: www.angelhairfoundation.org

Date of Application: _____
Client #: _____

Client Application Form

Any child or teen who is dealing with hair loss due to a medical condition and lives or is treated in the state of Oregon is eligible for an "Angel Hair" system. To apply, please print out, complete and mail an application form along with a prescription from your physician for a cranial prosthesis to the Angel Hair Foundation.

First Name: _____ MI: _____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email Address: _____
Birth Date (mm/dd/yyyy): _____ Age: _____ Sex: Female Male

Parent or Guardian Contact Info

First Name: _____ MI: _____ Last Name: _____
Cell/Work Number: _____ Email Address: _____
Relationship to Client: _____

Medical Information

Do you have a prescription for a cranial prosthesis?
Yes No If no, please call your physician and request one.

What is your medical diagnosis? _____

Are you currently undergoing medical treatment? Yes No

If yes, what type of treatment: _____

Have you already experienced hair loss? Yes No

Name of Your Physician: _____

Hospital Where Being Treated: _____



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Insurance Information

Insurance Company: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Group Number: _____ ID Number: _____

Employer: _____ Employee: _____

Referral Information

Name of Organization/Hospital: _____

Signature of Parent of Guardian: _____

Angel Hair Foundation is a private, non-profit organization that provides hair systems free to families who can't afford the \$1,500 cost.

For Office Use Only

Date Received: _____ By: _____

Date Approved: _____ By: _____