REQUEST FOR ASSISTANCE FORM

Please submit your completed form to CTDI_CARES@ctdi.com

A CTDI employee may request financial assistance up to a maximum of $1,000 per year for himself/herself and/or his /her immediate family members who are suffering from cancer or other serious illnesses.

DATE: _____

NAME: _____

ADDRESS: _____

_____

BRANCH: _____ **DEPARTMENT:** _____

EMAIL: _____

EXTENSION:_____

HOME OR CELL NUMBER: _____

HOW DID YOU HEAR ABOUT CTDI CARES? _____

Please state the nature of the request and the amount of assistance that you are requesting (Please note that, due to governmental regulations, we are unable to reimburse for medical expenses, co-pays or healthcare insurance premiums):

_____

_____

_____

_____

_____

SIGNATURE: _____ **DATE:**_____

FOR COMMITTEE USE ONLY

Date Received: _____ **Date Sent to Allocations Committee**: _____ **Approved (Y/N)** _____

Check Number: _____ **Check Amount:** _____