EPILEPSY FOUNDATION
Northwest

Emergency Medication Application Form

Instructions: (1) Print clearly (2) Complete entire form (3) Email to: mail@epilepsynw.org
-or- (4) Fax to: 206-400-1651.

- Forms not completely filled out will not be accepted.
- Application must be approved by EFNW staff and executive.
- One-time only allotment of $75 for emergency medication assistance.
- EFNW will only pay directly to and prescription must be held at a registered pharmacy.
- Applicant must verify with the pharmacy whether credit card payment via the phone is acceptable, or a check will need to be sent in regular mail to the pharmacy; which may delay fulfillment of payment.

Applicant Name _____ Date _____

Birth Date ____ Month _____ Date _____ Year Gender: Male ___ Female ___

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

E-mail Address _____

Doctor's Name _____

Address _____

City _____ State _____ Zip _____

Office Phone _____ E-mail Address _____

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Medication Requested _____ Prescription Number _____

Dosage _____ Total Price $ _____

Reason for assistance need: _____

_____

Staff Approval: _____ **Executive Approval:** _____