FOUNDATION FOR THE ADVANCEMENT OF CLINICAL TMS

Attachment C
Patient Assistance Fund Report

Date:

Clinic Name:

Person Completing Form:

Date Grant Received:

Total Grant Amount:

Total number of patients assisted:

	Gas Cards	Bus Voucher	Taxi	Hotel	Other
Patient 1					
Patient 2					
Patient 3					
Patient 4					
Patient 5					
TOTAL					

Representative Name: _____

Representative Signature:_____

Date: _____