DREAM WISH OR SPECIAL REQUEST
APPLICATION INSTRUCTIONS

Dear Applicant:

Cherished Creations, Inc. is a nonprofit organization dedicated to improving the quality of life for children and young adults with life-threatening illnesses by helping to fulfill their dream wishes and special requests. In order to qualify for this program, children and young adults (21 years of age or under) must meet the Eligibility Criteria as shown on the attached.

In order to be granted the dream wish or special request, an application package must be submitted and approved by the Cherished Creations, Inc. Board of Directors. For requests over $500, use the four-page application which consists of the following:

1. The Application itself which must be filled out by a Social Worker or a Doctor at the hospital or clinic where the wish-recipient is being treated. (Form 1)
2. An Attending Physician's Report which must be prepared by the child or young adult's attending physician. (Form 2)
3. A Parent/Guardian Questionnaire which must be completed by the child or young adult's parent(s) or guardian. (Form 3)
4. A Release Form which must be signed by the parent or guardian of the child or young adult and Witnessed by two adults. If the child or young adult is 18 or older, they can sign the Release Form. (Form 4)

For Requests under $500, use the single Application Form (Form 5).

Please mail or fax the forms to Cherished Creations. In all cases, the fulfillment of a Wish depends on the availability of resources, i.e. tickets, space, budget, etc.

During the review process, Cherished Creations, Inc. may request additional information as needed. If there are any questions or concerns, please call 908-790-0616 or e-mail us at info@cherishcreations.com

Yours truly,

Rich Martell
Executive Director

WR intro 6/2006

DREAM WISH OR SPECIAL REQUEST APPLICATION ***FORM 1***

CHILD /YOUNG ADULT'S NAME ______________________________________DOB: ____/____/____
(Please Print)

ADDRESS: ______________________________________City_________________________State ______Zip________

MOTHER'S NAME: _____________________________ _________________ TEL #: (_____) _________________
(Last) (First)

FATHER'S NAME: _____________________________ _________________ TEL #: (_____) _________________
(Last) (First)

GUARDIAN'S NAME: _____________________________ _________________ TEL #: (_____) _______________
(If applicable) (Last) (First)

E-MAIL ADDRESSES: _________________________________ ______________________________________
Parent/Guardian Child/Young Adult

DIAGNOSIS:___________________________ DATE FIRST DIAGNOSED:: ____/____/____

HOSPITAL: ____

ADDRESS: _____________________________________City_______________________State ______Zip________

PHYSICIAN: ____ TEL # (_____) _________________

SOCIAL WORKER: ____ TEL # (_____) _________________

Has child or young adult received a "wish" from another organization? Yes ______ No ______

Date: ___________Please provide details: ____

If so, what qualifies him/her for another wish at this time ?____

CURRENT WISH REQUEST:Please *describe child's/young adult's wish in detail, using additional paper if necessary.*

APPLICATION SUBMITTED BY: (Please print) ________________________________ DATE: _________________

"RELATIONSHIP TO" OR "ROLE WITH" APPLICANT: _________________________ TEL #:(____)___________

E-MAIL ADDRESS: ____

DREAM WISH OR SPECIAL REQUEST *FORM 2*
ATTENDING PHYSICIAN'S REPORT

CHILD'S NAME: (Please Print) ____ DOB:: ____/____/____

DIAGNOSIS: ____ DATE of DX. ____/____/____

IS ILLNESS LIFE-THREATENING? YES __ _____ NO ________

PROGNOSIS AT THIS TIME: GOOD _________ GUARDED _________ POOR __________

CURRENT TREATMENT: ____

Are you aware that this child or young adult has requested a dream wish or special request?

Yes _______ No ________ Please describe dream wish or special wish: _______________________

____

Does the child or young adult have any restrictions that might hinder the fulfillment of this request?

Yes ______ No _______ Please describe: ____

In your opinion, is the child or young adult's physical and/or emotional state adequate to fulfill dream wish or special request?

Yes ______ No ______ Please explain: ____

____

Do you know if child or young adult has had a "wish" granted by another organization?

Yes ______ No _____ Please provide details: ____

Do you recommend that the child or young adult be granted their dream wish or special request?

Yes _______ No ______ Comments: ____

____

ATTENDING PHYSICIAN'S NAME: (Please print) ____

HOSPITAL: ____

ADDRESS: ___________________________________City_______________________State ______Zip________

ATTENDING PHYSICIAN'S SIGNATURE: ____

DATE: _______________ TEL #: (_____) __________________ E-MAIL Address_______________________

DREAM WISH OR SPECIAL REQUEST PARENT/GUARDIAN QUESTIONNAIRE — *FORM 3*

CHILD'S NAME: (Please Print) ____ Soc. Sec. # ___________________

RESIDES WITH: __________________________________ RELATIONSHIP TO CHILD: ______________________

ADDRESS: _____________________________________City_________________________State ______Zip_______

TELEPHONE #: (Home) (_____)_______________ (Work) (______)________________ (Cell)________________

Which phone can we call during daytime hours?____

MOTHER'S NAME: (Please print) ____

FATHER'S NAME: (Please print) ____

GUARDIAN'S NAME: (Please print) ____
(If applicable)

ATTENDING PHYSICIAN: ____ TEL #: (_____) ________________

ADDRESS: ___________________________________City____________________________State ______Zip________

Are there other immediate family members residing in the home? Yes ______ No _______

NAME	RELATIONSHIP TO CHILD	AGE

Who has custody of child or young adult?:

MOTHER/FATHER: ________ MOTHER: ________ FATHER: _________GUARDIAN: __________

Has child or young adult ever had a "wish" granted by another organization? Yes ____ No _____

Please explain: ____

Do you have any reservations about news/media coverage? Yes ______ No _______

Please explain. ____

Does the child or young adult know the seriousness of their illness? Yes ______ No _______

Please advise us how we should handle the possible disclosure of the illness if a situation develops where it needs to be revealed? ____

If we need to send a package that requires a signature, to what name and address should we send it?

Name: ____ Phone # ____________________________________

Address ____

DREAM WISH OR SPECIAL REQUEST RELEASE *FORM 4*

I, the undersigned parent/guardian of _________________________ (referred to as the "child" in the rest of this document), in consideration of the granting and/or being involved in the granting of a dream wish/special request described as follows, ____________ ____ , for the child, do assume all risk of accident or damage, including property, to myself and/or the child and/or other immediate family members, and do release and discharge Cherished Creations, Inc. , its employees, agents, volunteers, Board of Directors and trustees of any claim and/or liability on account of any personal injury or damage of any kind sustained as the result of the carrying out of the dream wish/special request, described in this Release, on any trip and/or activity.

I authorize Cherished Creations, Inc., or any of its agents, employees, volunteers, Board of Directors and trustees to photograph, film and/or record interviews with me, the child and/or other immediate family members, as they shall choose, without any charge or payment to me. I also authorize Cherished Creations, Inc. or any person or organization participating in the taking of photographs, films or recorded interviews, covered by this Release, to distribute now or any time in the future all or any of the covered photographs, films and/or recorded interviews to anyone, including the public and to magazines, newspaper, television, and radio stations and/or any other organization which presents information to the public, without any charge or payment to me. I also authorize Cherished Creations, Inc. to disclose to the public as well as to television and radio stations, newspapers, magazines and other organizations, now or at any time in the future, the name of the child and to discuss any aspect of his/her physical and/or emotional condition.

It is my understanding that by signing this Release, any aspect of the child's physical or emotional condition may become public information and that I no longer have control over the disclosure of this information. I also acknowledge that the child may learn of his/her condition through other persons and that his/her condition may become common knowledge. It is not necessary for Cherished Creations, Inc. or any other person(s) or organization(s) to contact me prior to the release of any information, covered in this Release, to the public. I acknowledge that I have received the advice, counsel and authorization of the Attending Physician ________________________________, MD, and/or other legal advice, for the child to participate in the dream wish/special request as described above and this Release. I have relied upon both my legal and attending physician's advice in connection with this dream wish/special request and Release, and not on any statements made by Cherished Creations, Inc. or any person connected with it.

______________________________	______________________________	______________
(Mother/Father's Name - Print)	(Mother/Father's Signature)	(Date)
______________________________	______________________________	______________
(Guardian's Name - Print)	(Guardian's Signature)	(Date)

If child or young adult is 18 or older, he/she must also sign the release.

______________________________	______________________________	______________
(Wish Participant's Name - Print)	(Wish Participant's Signature)	(Date)

Witnesses: (Two must sign)

1. ______________________________ ______________________________ ______________

(Name - Print) **(Signature)** **(Date)**

Address: ____**City**____________________**State** ________

2. ______________________________ ______________________________ ______________

(Name - Print) **(Signature)** **(Date)**

Address: ____**City**____________________**State** ________

WR04-6/2006