



Spa Day Nomination Form

www.karenwellingtonfoundation.org/spa-day-nomination

Date: _____

How did you hear about The Karen Wellington Foundation? Name of person or source: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Your relationship to Nominee: _____

I would like to nominate ~ Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Birth Date: _____ Occupation: _____

When diagnosed: _____ Stage of Breast Cancer: _____

Brief Medical journey: _____

Medical Team - Primary Hospital: _____

Oncologist: _____ Address: _____

Surgeon: _____ Address: _____

What inspired your Nomination and how do you feel Nominee would benefit from a Spa Day from The Karen Wellington Foundation for LIVING with Breast Cancer:

Please return this form to Lisa Lape

EMAIL: Lisa.Lape@karenwellingtonfoundation.org

MAIL: Lisa Lape, 457 Maple Ridge Court, Cincinnati, OH 45244