Spina Bifida & Hydrocephalus Association of Ontario

2018 Dr. E. Bruce Hendrick Scholarship Program
Medical Assessment Form

NAME OF APPLICANT: _____ **DATE:** _____

SECTION ONE:
Type and Extent of Applicant's Disability

Primary Diagnosis: ☐ *Spina Bifida only* ☐ *Hydrocephalus only* ☐ *Spina Bifida & Hydrocephalus*

Additional/Other Condition: _____

EXTENT: _____

_____

_____

SECTION TWO:
Evaluation of Applicant's Functional Disability in Relation to Their Ability to Undertake the Proposed Program of Study

EVALUATION: _____

_____

_____

_____

NAME OF DOCTOR/
HEALTH CARE PROVIDER _____

ADDRESS OF DOCTOR/
HEALTH CARE PROVIDER _____

DOCTOR/HEATH CARE
PROVIDER SIGNATURE _____

This form is not required if you have submitted one with a previous year's application unless your medical information has changed significantly.

This form may be enclosed with the completed scholarship application or may be sent under separate cover to: Scholarship Committee, Spina Bifida and Hydrocephalus Association of Ontario at the address below. All application materials must be received at the Spina Bifida and Hydrocephalus Association of Ontario offices by **the last business day in April.**

Spina Bifida & Hydrocephalus Association of Ontario
16 Four Seasons Place, Suite 111, Toronto, Ontario M9B 6E5
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