HYDROCEPHALUS CANADA

**LUCIANA SPRING MASCARIN**
**BURSARY PROGRAM**

## 2023 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: Bursary Committee, Hydrocephalus Canada at the address below. All application materials must be received by **the last business day in March.**

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