HYDROCEPHALUS CANADA

DR. E. BRUCE HENDRICK
NATIONAL SCHOLARSHIP
PROGRAM

2024 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, Hydrocephalus Canada at the address below. All application materials must be received by **April 30, 2024.**

16 Four Seasons Place, Suite 111, Toronto, Ontario M9B 6E5
Phone 416-214-1056 • 800-387-1575 • Fax 416-214-1446
email: info@hydrocephalus.ca • www.hydrocephalus.ca
Charitable Registration #10799 9310 RR0001