HYDROCEPHALUS CANADA

LUCIANA SPRING MASCARIN
BURSARY PROGRAM

2025 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 **March 31.**

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