



DR. E. BRUCE HENDRICK  
NATIONAL SCHOLARSHIP PROGRAM  
2026 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/HEALTH 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, 2026**.