

BRAINWAVES HYDROCEPHALUS CANADA



DR. E. BRUCE HENDRICK ONTARIO 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/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: Scholarship Committee, Hydrocephalus Canada at the address below. All application materials must be received by **the last business day in April**.