
LUCIANA SPRING MASCARIN BURSARY PROGRAM

Named in honour of
Luciana Spring Mascarin

established, supported and directed by
The Spina Bifida and Hydrocephalus Association of Ontario

APPLICATION FORM

for 2010 bursaries

**Windsor & Chatham-Kent area residents only are eligible to
apply for this bursary.**

This is an application form for a bursary administered by the Spina Bifida and Hydrocephalus Association of Ontario. To ensure that you will be considered for this bursary, please answer all of the questions carefully. All information supplied on this form will be considered by the committee. Falsification of any information will result in automatic rejection of the application.

Forward two copies of the completed application form by **March 31, 2010** to:

SPINA BIFIDA & HYDROCEPHALUS ASSOCIATION OF ONTARIO
Luciana Spring Mascarin Bursary Program
555 Richmond Street West, P.O. Box 103, Suite 1006
Toronto, Ontario M5V 3B1
fax: 416-214-1446
email: provincial@sbhao.on.ca

If you fax or e-mail your application you must also submit the original documents by mail.
Please print or type all information.

Name: _____

Mailing Address: _____

Postal Code: _____ Telephone #: _____

Home Address: _____

Email Address: _____

Date of Birth: _____

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Name of the university or other educational facility you plan to attend this fall. Please enclose evidence of acceptance or forward that evidence when you receive it.

Proposed course of study:

State your future educational and career objectives.

Name other scholarships or bursaries which you expect to receive this year or for which you have applied, this year.

		will receive	have applied
Name: _____	Amount: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	Amount: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	Amount: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Name any scholarships, awards, bursaries, medals or certificates of recognition that you have previously received (with dates).

Name: _____ Date: _____

Name: _____ Date: _____

Name: _____ Date: _____

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Estimate the total cost of your education for the next year. Provide a breakdown of expenses (i.e. tuition, books, travel, residence, specialized equipment/services to support your education program, etc.)

Are you receiving:

	YES	NO
Ontario Disability Support Benefits	<input type="checkbox"/>	<input type="checkbox"/>
Student Loans/Grants	<input type="checkbox"/>	<input type="checkbox"/>

Have you applied for:

	YES	NO
Ontario Disability Support Benefits	<input type="checkbox"/>	<input type="checkbox"/>
Student Loans/Grants	<input type="checkbox"/>	<input type="checkbox"/>

State how you expect to finance your education:

List your employment history including full-time, part-time and summer jobs, co-op placements and volunteer work.

List your hobbies and special interests.

IMPORTANT

Two copies of this application form plus the following documents must be received in the Spina Bifida and Hydrocephalus Association of Ontario offices by **March 31, 2010**.

If you fax or e-mail these documents you must also submit the originals by mail.

- Academic transcript (include the most recently completed semester)
- The medical assessment form (not required if you have previously applied unless your situation has changed)

Applications received after March 31, 2010 cannot be considered.

I affirm that the information in this application is correct and complete.

Date:

Signature: