



**THE LUCIANA SPRING MASCARIN BURSARY PROGRAM  
2010 MEDICAL ASSESSMENT FORM**

**DATE:** \_\_\_\_\_

**NAME OF APPLICANT:** \_\_\_\_\_

**SECTION ONE:  
TYPE AND EXTENT OF APPLICANT'S DISABILITY**

**PRIMARY DIAGNOSIS:**

*Spina Bifida only*                       *Hydrocephalus only*                       *Spina Bifida & Hydrocephalus*

**EXTENT:**

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**SECTION TWO:  
EVALUATION OF APPLICANT'S FUNCTIONAL DISABILITY IN RELATION TO HIS/HER ABILITY TO  
UNDERTAKE THE PROPOSED PROGRAM OF STUDY**

**EVALUATION:**

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**NAME OF DOCTOR** \_\_\_\_\_

**ADDRESS OF DOCTOR** \_\_\_\_\_

**DOCTOR'S 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, Spina Bifida and Hydrocephalus Association of Ontario at the address below. All application materials must be received at the Spina Bifida and Hydrocephalus Association of Ontario offices by **March 31, 2010**.

Spina Bifida & Hydrocephalus Association of Ontario

555 Richmond Street West, P.O. Box 103, Suite 1006, Toronto, Ontario M5V 3B1  
(416) 214-1056 ● (800) 387-1575 ● Fax (416) 214-1446

Email: [provincial@sbhao.on.ca](mailto:provincial@sbhao.on.ca) ● [www.sbhao.on.ca](http://www.sbhao.on.ca) ● Charitable Registration # 10799 9310 RR0001