DR. E. BRUCE HENDRICK SCHOLARSHIP PROGRAM
2011 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: ____

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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: Scholarship 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 **April 29, 2011.**