



**DR. E. BRUCE HENDRICK SCHOLARSHIP PROGRAM
2012 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 HIS/HER ABILITY TO
UNDERTAKE THE PROPOSED PROGRAM OF STUDY**

EVALUATION: _____

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 30, 2012.**