



# SBHASA BURSARY APPLICATION

This is an application for a bursary administered by the Spina Bifida and Hydrocephalus Association of Southern Alberta (SBHASA). 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 confidential by the executive. Falsification of any information will result in automatic rejection of the application.

Please print this application and confine your responses to the space available.

Applications must be submitted by mail (no faxes).

Name: \_\_\_\_\_  
(surname) (first) (middle)

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Insurance Number \_\_\_\_\_

This application form plus the following documents must be received:

- a) Confirmation of enrollment. \*
- b) Academic transcript for last school attended.\*
- c) Medical assessment form completed and signed by a physician. \*
- d) One letter of reference from an adult other than a family member, such as a minister, youth group leader, coach or volunteer supervisor. \*
- e) A letter stating why you think you are deserving of this award. This is your opportunity to tell us about yourself.

\* These materials may be sent separately.

Please return your completed application form, along with supporting documentation, to:  
Spina Bifida and Hydrocephalus Association of Southern Alberta  
Bursary Program  
P.O. Box 6837 Station "D"  
Calgary, Alberta  
T2P 2E9

For more information, contact:(403) 263-1109

Name of the educational facility you plan to attend. Please enclose confirmation of enrollment or forward the confirmation when you receive it.

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Proposed course of study: \_\_\_\_\_

State your future educational and career objectives: \_\_\_\_\_

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List in chronological order the schools that you have attended and grades that you have completed.

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Name other scholarships or bursaries for which you have applied for this year.

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List your hobbies and special interests.

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I hereby certify that the information given here is true, correct and complete to the best of my knowledge and if I receive a scholarship, will allow my name to be published.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SBHASA BURSARY PROGRAM

## Medical Assessment Form

Name of Applicant: \_\_\_\_\_  
(surname) (first) (middle)

Name of Physician: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**Section One: Type and Extent of Applicant's Disability**

Spina Bifida: \_\_\_\_ Hydrocephalus: \_\_\_\_ Attends Myelo Clinic at ACH: \_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section Two: Evaluation of Applicant's Functional Disability in Relation to His/Her Ability to Undertake the Proposed Program of Study**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form may be enclosed with the completed scholarship application or may be sent under separate cover to:

Spina Bifida & Hydrocephalus Association of Southern Alberta  
P.O. Box 6837 Station "D"  
Calgary, Alberta T2P 2E9  
Telephone: (403) 263-1109