2024 Tri-State Bleeding Disorder Foundation

SCHOLARSHIP APPLICATION

SECTION I

1. I am applying for the following scholarship(s) (check scholarship being applied for). Applicant may apply for both scholarships, if eligible.

   ☐ TD Hughes, Jr Scholarship ☐ Gina Stack Memorial Scholarship

2. Last Name_____________________________ First Name __________________________________

3. Mailing Address:

   Street: ____

   City:______________________________________State:_______________ZIP: ________________

4. Applicant's contact information:

   Phone: (   ) - ____________________________________ Email Address: _____________________

5. Date of Birth: Month_______Day__________Year ________________

6. High School (if recent graduate), or institution currently attending:

   ____

7. College/University/Technical School/Graduate School Class you will be entering *(please check one):*

   ☐ Freshman ☐ Sophomore ☐ Junior
   ☐ Senior ☐ Graduate

8. College/University/Technical School/Graduate School for which scholarship is intended:

   ____

9. Are you taking classes on the main campus or a satellite campus? ________________________________

10. Year of anticipated graduation from College/University/Technical School/Graduate School _____

11. Grade Point Average (GPA):_______________(On a 4.0 scale). Attach proof of GPA. Your most recent unofficial or official transcript is required.

12. What is your major/degree? If major is undeclared, state reason.

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13. List other financial assistance you will receive per semester or quarter:

    A. Other scholarship(s)______________________________________Amount: ___________________

    ____

    B. Student Loans(s)____Amount: ___________________

14. List any scholarships and year received that you were previously awarded from the Tri-State Bleeding Disorders Foundation (if none, state NONE):

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15. Do you have a bleeding diagnosis or are you an immediate family member of a person with a bleeding disorder? Self: Family member:

    Relationship to person with bleeding disorder: _______________________

    Bleeding diagnosis: ____

    Name of person with bleeding disorder if not yourself: _____________________________________

    Name of current hematologist or Hemophilia Treatment Center : ________________________________

16. List your academic honors, awards, and membership activities Include the year(s) you received the award/honor and year(s) of membership activities. For the 2nd or subsequent year of a TSBDF scholarship application only list those for the past year.

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17. List your community service activities, hobbies, outside interests, and extracurricular activities, including those associated with the bleeding disorders community. For the 2nd or subsequent year of a TSBDF scholarship application only list those for the past year.

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18. List the name of the person who will be sending in a recommendation letter on your behalf (required for first-time applicants only). Recommendation letters from relatives are not acceptable.

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19. Do you have financial need or extreme challenges? If so, please explain in general terms:

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20. List your FAFSA score (Free application for Federal Student Aid) if available: ____________________

21. List your goals, aspirations, and choice of major**: NOTE: Applicants of the Gina Stack Memorial Scholarship must be pursuing a full-time degree program with a focus on the healthcare or medical profession.**

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SECTION II

ESSAY: On a separate sheet/s of paper, please submit your response as a typed, 12-point font, double-spaced essay with a 600-word maximum. Submit as an attachment with your scholarship application. Your essay should include the following:

- Your career objective
- Why you have chosen this field
- Your personal characteristics that will contribute to your success in attaining your education and career goals
- How your bleeding disorder (or your family member's bleeding disorder) influenced your career objective

For applicants applying for a second or subsequent year scholarship: Instead of the essay question listed above, please submit in 600 words or less, double spaced on a separate sheet(s) of paper:

- A brief review summarizing your progress for the recent academic year along with your future plans.
- What advice would you be willing to share with younger students preparing to enter college or technical school?

ACKNOWLEDGEMENT

- I hereby affirm that all the above stated information provided by me is true and correct to the best of my knowledge.
- I hereby understand that if chosen as a scholarship winner, I must provide evidence of enrollment/registration at an accredited, post-secondary institution before my scholarship funds can be awarded.
- I hereby affirm that if I withdraw from school within my institution's window to receive a tuition refund, I will return the scholarship to TSBDF.
- All applications and communications must come directly from the applicant. Applications will not be accepted from anyone other than the applicant.
- I hereby acknowledge that the medical information you are providing to T.S.B.D.F. will be shared with the scholarship selection committee as part of your application.

Signature:____ Date: ___________________________

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SECTION III

PERSONAL/PROFESSIONAL REFERENCE FORM

Note to the applicant: Please complete the top portion of this form and then send it to the person who knows you well enough to recommend you for this scholarship. References from family members are not acceptable.

All reference letters must be emailed to Hemophilia@TSBDF.com by June 1, 2024 or mailed to:

Helen Lamping
Tri-State Bleeding Disorder Foundation
635 W Seventh Street STE 407
Cincinnati OH 45203

Mailed reference letters must by post-marked by June 1, 2024.

Applicant's Name ____

Address____

College______________________Major ______________________

* * * * * * * * * * * *

Instructions to the Reference: *The person named above is applying for a Tri-State Bleeding Disorder Foundation Scholarship. The information given in this recommendation will not be available to the above applicant. Please email to: Hemophilia@TSBDF.com.*

How long have you known the applicant? ______________________________

In what capacity have you known the applicant?______________________________

Please describe in detail why you are recommending this person for the Tri-State Bleeding Disorder Scholarship. Please comment on the applicant's strengths and weaknesses, intellectual ability, achievement motivation, ability to work with others, relevant accomplishments, or any other characteristics that would help in determining merit of this applicant. You may use a separate sheet of paper.

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Name of Reference:______________________Title:

Signature: ____

Address:____

City______________________State__________Zip __________

Phone (___)______________________Email______________________

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SECTION IV
DOCUMENTATION OF A BLEEDING DISORDER BY HEMATOLOGIST OR TREATMENT CENTER PHYSICIAN/NURSE

Note to the applicant: Please complete the top portion of this form and then give it to the treating hematologist or their nurse who can document your diagnosis of a bleeding disorder. If it is your immediate family member who has a bleeding disorder diagnosis, documentation of that family member's diagnosis and their relationship to you is required.

Applicant should complete the following:
Person diagnosed with bleeding disorder:______________________________

Date of birth of person with bleeding disorder (MM/DD/YYYY): ______________________________

Scholarship applicant's name: ______________________________

Scholarship applicant's address ______________________________

City______________________________State__________Zip __________________

If the scholarship applicant is not the person with the bleeding disorder, what is the relationship of the scholarship applicant to the person with the bleeding disorder? ______________________________

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Note to the hematologist/nurse of record treating the person identified above who is diagnosed with a bleeding disorder: Please email directly to patient.

The above-named applicant has applied for a Tri-State Bleeding Disorder Foundation Scholarship. Eligibility requires that the scholarship applicant be diagnosed with a documented bleeding disorder, such as hemophilia, von Willebrand Disease or other bleeding disorder, or be an immediate family member of a person with a documented bleeding disorder. The applicant must live within the 16-county area served by the TSBDF and must be pursuing a full-time post-secondary education program at an accredited university/college or technical school. They are giving you permission to verify their diagnosis, or that of their family member.

Name of person diagnosed with the bleeding disorder:

____

Bleeding Diagnosis and Clinical Severity:______________________________

____

Is this person an active patient currently receiving treatment at your treatment

☐ Yes ☐ No

How long has this person been treated at your treatment center/clinic/office:______________________________

In your opinion, please comment on the suitability of this applicant for a Tri-State Bleeding Disorder Foundation Scholarship (please use a separate sheet of paper if desired):

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Hematologist/Nurse Name (Include degree: e.g., M.D, D.O., R.N., MSN, etc.):

Name (Print):______________________________________Title:______________________

Signature:____

Address:____

City_____________________________________State____________Zip __________

Phone (______)____________________Email____________________________________

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SECTION V

PROOF OF ENROLLMENT OR LETTER OF ACCEPTANCE TO A COLLEGE OR TECHNICAL SCHOOL – TO BE SUBMITTED WITH SCHOLARSHIP PACKET

SECTION VI

COPY OF THE MOST RECENT TRANSCRIPT WITH CUMULATIVE GRADE POINT AVERAGE (GPA) – TO BE SUBMITTED WITH SCHOLARSHIP PACKET