Tri-State Bleeding Disorder Foundation
2025 SCHOLARSHIP APPLICATION

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

Note to the applicant: <u>Please complete the top portion of this form</u> 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):

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_____