



Tri-State Bleeding Disorder Foundation
2026 SCHOLARSHIP APPLICATION

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. Must be received by TSBDF no later than June 1, 2026.

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? _____

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 or their immediate family member with a bleeding disorder must live within the geographic area served by the TSBDF or be followed at either the pediatric or adult hemophilia treatment center in the Greater Cincinnati area. They must be pursuing a full-time post-secondary education program at an accredited university/college or technical school or be enrolled as a student in a graduate school program. 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 _____