SandsRx Scholarship Application Form 2023

TYPE OR CLEARLY PRINT ALL INFORMATION IN DARK INK.
All parts of the application must be completed in its entirety and sent with other required documents by the application deadline. Incomplete applications will not be considered for submission. This scholarship application form has been designed to give each applicant fair and equal consideration. Please send the completed form along with requested documents via email at: **nhfadvancement@hemophilia.org** * All information received will be treated for the sole purpose of this scholarship.

Parent/Guardian's Statement
I have reviewed the information on this form and give permission for my child to submit this application and its procedures. I authorize my child's school to release the necessary information for this application.

PARENT/GUARDIAN'S NAME: _____

PARENT/GUARDIAN'S EMAIL: _____

PARENT/GUARDIAN'S NUMBER: _____

PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____

Student Applicant's Statement
I certify that all the information I have provided is accurate and true, to the best of my knowledge.

APPLICANT'S SIGNATURE: _____ DATE: _____

PART 1. PERSONAL INFORMATION

Full Name (first, middle initial, last name) _____

Age _____ Date of Birth (mm/dd/yyyy) _____

Home Address _____

City, State, Zip _____

Phone (student) _____

Email (student) _____

Current School and Grade _____

Current Cumulative GPA (on a 4.0 scale) _____

School and Grade you plan to attend the upcoming school year_____

School Start Date (mm/ yyyy) _____

Projected Graduation Date (mm/yyyy) _____

Please note: For Part 2 through 4, please indicate the month and year that you completed the activity. You may use a separate sheet of paper if necessary. If including a resume, please ensure the areas included below are clearly identified.

PART 2. SCHOOL-RELATED LEADERSHIP AND EXTRACURRICULAR ACTIVITIES (e.g., clubs, honor societies, etc.)

Scholastic Honors / Awards (State nature of honor or award and year – such as National Honor Society)

Other Honors / Awards (State nature of honor or award and year)

Academic / Social / Other (Name of organization and year – include leadership position/office, if applicable)

Sports (List sport and include year and position held)

PART 3. NON-SCHOOL-RELATED EXTRACURRICULAR ACTIVITIES & EMPLOYMENT (e.g., community, church, scouting, 4-H, social clubs, summer jobs, etc.)

Organization Name (include year and leadership position/office held, if applicable)

Honors / Awards (State nature of honor or award and year)

PART 4. VOLUNTEER ORGANIZATIONS

Include organization name, position held/duties performed, year, and hours spent volunteering

PART 5. PRINCIPAL OR SCHOOL GUIDANCE COUNSELOR'S ENDORSEMENT

The Principal or School Guidance Counselor currently having supervisory responsibility for the applicant is asked to fill out the following information and sign this endorsement certifying he/she reviewed the application and verifies the accuracy of the information pertaining to the academic standing and school-related activities of the applicant.

Please provide the following information along with a copy of the student's most recent school transcript.

Student Name: _____

Number of Students in Class: _____

Student's Rank in Class: _____

Cumulative GPA (must be 2.5 or higher): _____

ACT and/or SAT Score (high school students only): _____

Principal/Guidance Counselor Statement

This information and the submitted transcripts have been reviewed by me and to the best of my knowledge accurately represents the student listed above.

PRINCIPAL/ GUIDANCE COUNSELOR'S NAME AND TITLE: _____

PRINCIPAL/ GUIDANCE COUNSELOR'S SIGNATURE: _____

DATE: _____

**Please note- The applicant must have Part 5: Principal/Guidance Counselor's Endorsement completed along with a copy of their school transcript for this application to be eligible for evaluation by the scholarship committee.*

PART 6. CLINICIAN FORM

The following must be completed by Healthcare Provider (HCP) overseeing the applicant's bleeding disorder:

Patient's Name: _____

Diagnosis (check one):

☐ Hemophilia A ☐ Hemophilia B ☐ VWD ☐ Other Bleeding Disorder: _____

Hemophilia Treatment Center or Healthcare Facility Name: _____

Healthcare Facility Address: _____

Healthcare Provider (HCP) Statement

I have reviewed the provided information and acknowledge that all information is true and accurate as listed above.

HCP NAME AND TITLE: _____

TYPE OF HCP: _____

NPI: _____

HCP SIGNATURE: _____

DATE: _____

**Please note- The applicant must have Part 6: Clinician Form completed for this application to be eligible for evaluation by the scholarship committee.*