EDUCATION Advantage

Scholarships for our community.

GED Assistance Program

APPLICANT INFORMATION (PLEASE PRINT - illegible writing may delay the processing of your application.)

To the Applicant: *Print this page, complete Applicant Information and provide form to the appropriate Healthcare Provider to complete remaining information. All information is required. If incomplete, your application will not be evaluated. Upload the completed form as part of your application along with a copy of your GED certification.* ***Applications must be submitted within 6 months of GED certification.***

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ ZIP Code _____

Email (required) _____ Phone (____) _____

HEALTHCARE PROVIDER VERIFICATION

To the Healthcare Provider: *You have been asked to verify that the applicant is diagnosed with hemophilia A or B, including those with inhibitors (Factor VIII or IX deficiency or Von Willebrands). Please complete, sign and return this form to the applicant. Thank you for your assistance*.

Provider's Last Name (print) _____ First _____ MI _____

Job Title/Type of Provider _____

Name of Healthcare Facility _____

Facility's street address _____

City _____ State _____ Phone (_____) _____

Diagnosis: ☐ Hemophilia A ☐ Hemophilia B ☐ Von Willebrands

Please indicate severity of the applicant's hemophilia A or B or Von Willebrands (% of normal factor activity in blood):

☐ Severe (Less than 1%) ☐ Moderate (1% to 5%) ☐ Mild (5%-40%)

How long has the applicant been under your medical supervision? _____

Healthcare Provider's Signature _____ Date _____

Upload the completed form as part of your application.
Applications must be submitted within 6 months of GED completion.