MEDICAL VERIFICATION FORM: Education Advantage Scholarship Program

Please complete the following information so this form can be matched to your electronic application.

Applicant's Last Name _____ First _____ Middle Initial _____

Applicant's Address (Street or PO Box) _____

City _____ State _____ ZIP _____ Date of Birth: Month _____ Day _____ Year _____

APPLICANT VERIFICATION

To the Applicant: Print this page, complete this section and provide form to the appropriate Healthcare Provider to complete remaining information. *This information is* ***required.*** *If incomplete, your application will not be evaluated. Upload the completed form as part of your application to Scholarship America with all other required documents. Applications must be submitted no later than* ***3:00 p.m. Central Time on July 16, 2020****.*

The Education Advantage program is open to people with hemophilia A or B, including those with inhibitors (Factor VIII or IX deficiency), or von Willebrand Disease:

I have been diagnosed with hemophilia A ☐ or B ☐, or von Willebrand Disease ☐

Do you have joint damage from bleeds? ☐ Yes ☐ No

Have you had surgery for joint damage? ☐ Yes ☐ No

Name of healthcare provider you see for hemophilia or von Willebrand Disease treatment (print) _____

Do you visit a Hemophilia Treatment Center (HTC) for your treatment? ☐ Yes ☐ No If yes, please provide:

HTC name: _____ Phone (_____) _____

If no, where do you receive treatment? _____

Name of primary contact that you see regularly to treat your hemophilia, or von Willebrand Disease: _____

Do you attend comprehensive clinic on an annual basis? ☐ Yes ☐ No

If no, why not? _____

How often do you see or communicate with your hemophilia, or von Willebrand Disease treating physician? _____

I authorize the Healthcare Provider to provide the following information in conjunction with my Education Advantage Scholarship application.

APPLICANT'S SIGNATURE _____ **Date** _____

HEALTHCARE PROVIDER VERIFICATION

To the Healthcare Provider: *You have been asked to provide information in support of this application. Please answer the following questions.* ***When complete, please return to applicant in a sealed envelope.*** *Thank you for your assistance.*

Provider's Last Name (print) _____ First _____ Middle Initial ____

Job Title/Type of Provider _____

Name of Healthcare Facility _____

Facility's Street Address _____

City _____ State _____ Phone (_____) _____

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

MEDICAL VERIFICATION FORM: Education Advantage Scholarship Program

Severity of the applicant's hemophilia A ☐ or B ☐, or von Willebrand Disease ☐ (% of normal factor activity in blood):

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

Extent of joint disease:

☐ Severe ☐ Moderate ☐ Mild ☐ No joint disease

Surgeries: Number _____

Type(s) _____

_____

Patient's compliance with healthcare provider's recommendations:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What has been the impact of hemophilia, or von Willebrand Disease on the applicant's ability to perform in school (if known)?:

_____

_____

_____

Additional comments (optional):

_____

_____

☐ By checking this box I acknowledge that I do not wish to be contacted by Takeda Pharmaceuticals Company Limited in the occurrence that an Adverse Event is reported (intentionally or inadvertently) in the Education Advantage application materials for the above stated applicant.

Healthcare Provider's Signature _____ Date _____