DIAGNOSIS VERIFICATION FORM

2024 Education Scholarship for Wisconsin Sickle Cell Patients

For this verification to be accepted, it must be <u>completed by your physician</u> and uploaded with your application.

The Education Scholarship for Wisconsin Sickle Cell Patients is designed to provide financial support for exceptional students living with Sickle Cell Disease.

Eligibility requirements: Applicants must have been diagnosed with Sickle Cell Disease by a healthcare professional.

It is not necessary for applicants to have been treated in Children's Hospital of Wisconsin; this will not be a consideration in the recipient-selection process.

RELEASE OF INFORMATION TO BE COMPLETED BY APPLICANT

I, _____ on _____
*(**Printed** name & signature of applicant)* *(Date)*

If applicant is under the age of 18:

_____ on _____
(Printed parent/guardian name & signature of parent/guardian) *(Date)*

authorize _____ _____
(Printed name of physician)

to release to Scholarship America information regarding my disease diagnosis to show I meet eligibility requirements for the Education Scholarship for Wisconsin Sickle Cell Patients.

THIS SECTION TO BE COMPLETED BY PHYSICIAN

I certify that _____ is under my medical care and has been diagnosed with: Sickle Cell Disease None

_____ on _____
(Physician's Signature) *(Date)*

Physician's email: _____

Physician's telephone # (_____)_____ Physician's Fax # (_____) _____

Physician's address: _____

This information will be used only for the Education Scholarship for Wisconsin Sickle Cell Patients and will be treated with utmost confidentiality.