DIAGNOSIS VERIFICATION FORM

Education Scholarship for Wisconsin Sickle Cell Patients

For this verification to be accepted, it must be completed by your physician 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.

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.