The Sickle Cell Disease Association of Florida, Inc.
Dr. Charles B. McIntosh, M.D./Dr. Betty Bigby-Young, Ph.D.
Educational Assistance Award Application
Deadline May 1st

NOTE: Please PRINT or TYPE. ***Incomplete application will not be processed.***

Date: _____ 200_____

1. Name: _____ SS#: _____/___/_____

2. Address: _____ APT #: _____

3. City: _____ ZipCode: _____ Phone: (____)_____

4. Date of high school graduation: _____ Current GPA: _____

5. College, university or vocational school you are currently enrolled or have been accepted: _____

6. List and describe church or community service activities that you participated in within the past two (2) years. _____
_____
_____

7. List any awards, recognitions or personal achievements received from school or community organizations: _____
_____
_____

8. Name, address, telephone number of church or community reference writing letter on your behalf: _____
_____

8. Name, address, telephone number of educator or school administrator reference writing letter on your behalf: _____
_____

9. List and describe financial assistance amounts currently awarded or you anticipate:

TYPE (Loan, scholarship, grant, etc)	AMOUNT	PROVIDER	RECEIVED		ANTICIPATED	
			YES	NO	YES	NO

10. Describe financial assistance that you will receive from your family toward your education: _____
_____
_____
_____

MEDICAL VERIFICATION

Date: _____

This is to verify that _____is under my medical care and
Patient's Name
has a diagnosis of _____, a form of sickle cell disease.

_____ is ____ is not _____ approved to attend school
Patient's Name
_____full-term _____half-time Other (explain) _____
_____
_____

_____ _____
Physician name (Please Print) *Physician Signature*

_____(____)_____
Address *City* *State* *Zipcode* *Phone*

LOCAL CHAPTER VERIFICATION

Chapter: _____ Date: _____

This is to acknowledge that the Education Assistance Award Application for

_____ has been review and approved for submission.
Applicant's name

_____ _____
Please Print Name *Signature*

_____
Title/Position

APPLICANT'S DECLARATION

I declare that all information reported on this application is true. I also affirm that for the duration of this educational assistance award, I will continue to complete my chosen field of study. I understand this award is not transferable and should I withdraw from school for any reason, the award will be forfeited. I further understand that upon my written request, medical reasons may be ground for reconsideration.

Applicant's Signature: _____ Date: _____

Notary: _____ _____
Please Print Name *Signature*

Notary Seal *Date:* _____