THE SPINA BIFIDA AND HYDROCEPHALUS ASSOCIATION OF BRITISH COLUMBIA

4480 Oak Street, Vancouver, B.C. V6H 3V4
Ph: (604) 878-7000 - Fax: (604) 677-6608

Bursary Program
Medical Assessment Form

Date: _____

Name of Applicant: _____
(surname) (first) (middle)

Name of Doctor: _____

Mailing Address: _____

_____

Postal Code: _____ Telephone: _____

Section One: Type and Extent of Applicant's Disability

Spina Bifida:_____ Hydrocephalus:_____ Spina Bifida & Hydrocephalus:_____

_____

_____

_____

Section Two: Evaluation of Applicant's Functional Disability in Relation to His/Her Ability to Undertake the Proposed Program of Study

_____

_____

_____

_____

Doctor's Signature: _____

This form may be enclosed with the completed bursary application or may be sent under separate cover to:

Bursary Committee
The Spina Bifida & Hydrocephalus Association of B.C.
4480 Oak Street
Vancouver, B.C. V6H 3V4