THE GLADYS STREET FOUNDATION, INC. MEDICAL VERIFICATION FORM

MEDICAL VERIFICATION FORM: The Gladys Street Foundation, Inc.

Please complete the following information so this form can be included with your 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 the remaining information. This information is required. If incomplete, your application will not be evaluated. Include the completed form as part of your application to The Gladys Street Foundation, Inc. with all other required documents. Applications must be submitted no later than **3:00 p.m. Central Time on March 31** of the scholarship year. The Gladys Street Foundation, Inc. scholarship is open to adults 18-30 years living with sickle cell disease.

I have been diagnosed with sickle cell disease type _____

Name of healthcare provider you see for sickle cell disease (print)

_____

Do you visit a Sickle Cell Disease Comprehensive Center (SCDCC) for your treatment?

Yes ☐ No ☐

Please provide: SCDCC name: _____

_____

Phone _____

If no, where do you receive treatment? _____

_____

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Name of primary contact that you see regularly to treat your Sickle Cell 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 treating physician? _____

_____

I authorize the Healthcare Provider to provide the following information in conjunction with my The Gladys Street Foundation, Inc. Scholarship application.

APPLICANT'S SIGNATURE _____ Date _____