



THE SPINA BIFIDA AND HYDROCEPHALUS ASSOCIATION OF BRITISH COLUMBIA

102- 15910 Fraser Highway, Suite 228 Surrey BC V4N 0X9

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.
102-15910 Fraser Highway, Suite 228
Surrey, B.C. V4N 0X9