HISTIO STUDENT SCHOLARSHIP PROGRAM

HISTIOCYTOSIS™ ASSOCIATION
A Rare Community™

DIAGNOSIS VERIFICATION FORM

Histiocytosis Association Student Scholarship Program

THE HISTIOCYTOSIS ASSOCIATION has established the Histio Student Scholarship Program to celebrate the many advances in research and medicine that are now making it possible for young adult Histio Warriors to step into that next phase of life and chase their dreams as college students.

Eligibility Requirements and other related information can be found at https://histio.org/resource-overview/scholarship-program/.

Awards are granted without regard to race, color, creed, religion, sexual orientation, gender, disability, or national origin.

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 name & signature of parent/guardian) (Date)

authorize
____
(Printed name of physician)

to release to Histiocytosis Association information regarding disease diagnosis to show I meet eligibility requirements for the Histiocytosis Association Student Scholarship Program.

THIS SECTION TO BE COMPLETED BY PHYSICIAN

I certify that ____ is/was under my
(Name of patient)
medical care and has been diagnosed with: ____.
(Histiocytic disorder)

Physician's telephone # (______) ____________________

Physician's address: ____

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____ ________________
(Physician's Signature) (Date)

This information will be used only for the Histiocytosis Association Student Scholarship Program and will be treated with utmost confidentiality.