

UCB FAMILY EPILEPSY SCHOLARSHIP PROGRAM™

Provided by UCB, Inc.



DEADLINE: April 20, 2012

PURPOSE AND AWARD

The purpose of this scholarship program is to provide financial support for the education of people living with epilepsy, including patients, family members, and caregivers. UCB, Inc. seeks to recognize the personal achievements of those people living with epilepsy.

The award is a one-time scholarship in the amount of \$5000. Thirty scholarships will be awarded to people living with epilepsy, and family members or caregivers of people living with epilepsy, for use toward tuition at a United States-based center for higher learning (trade school, associate's, bachelor's, master's degree, etc).

ELIGIBILITY REQUIREMENTS

To apply, you must certify that you are:

1. A US citizen and/or a legal and permanent resident of the United States
2. A person living with epilepsy or a family member and/or caregiver of a person living with epilepsy
3. Seeking an undergraduate or graduate degree
4. A student who demonstrates achievement, possesses a strong record of participation in activities outside of school, and serves as a positive role model
5. Graduating from high school in 2012 or have already graduated from high school
6. Enrolled in, or awaiting acceptance from, a United States-based center for higher learning for fall semester 2012
7. Not a previous recipient of the UCB Family Epilepsy Scholarship™

PROCEDURES

To apply, please submit a completed application and all required support documents listed below postmarked by **April 20, 2012**.

- Sections of the application will need to be completed by the student, a parent/guardian (if the applicant is under 18), a school official, a member of the community, and a member of the applicant's healthcare team.
- Selection will be based on the following criteria, which must be included:
 - A one-page essay authored by the applicant explaining why he or she should be selected for the scholarship (eg, outstanding awards, community involvement, etc.), how epilepsy has impacted the applicant's life, either as a person living with epilepsy or as a family member/caregiver, and how the scholarship will benefit the applicant.
 - 3 letters of recommendation (recommendation letters from parents will not be accepted)
 - School official's recommendation letter (Section 2)
 - Community member's recommendation letter (Section 3)
 - Healthcare team member's recommendation letter (Section 4)
 - Medical History form
 - An original copy of the applicant's official academic transcript (Section 2)
- Students pursuing degrees in the arts are welcome to include an artistic presentation. This is an optional item.
- Additional pages can be attached to the application if more space is needed for responses.

You are encouraged to apply online at www.ucbepilepsyscholarship.com. Hard-copy applications can be mailed to the following address:

UCB Family Epilepsy Scholarship Program™
c/o Hudson Medical Communications
120 White Plains Road, 2nd Floor
Tarrytown, NY 10591

BE SURE TO COMPLETE AND POSTMARK APPLICATION BY THE DEADLINE OF APRIL 20, 2012.

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SECTION 1: TO BE COMPLETED BY APPLICANT (Response required on ALL fields)

APPLICANT INFORMATION (Please Print or Type)

Name: _____

Permanent Home Address (no PO boxes): _____

City: _____ State: _____ ZIP: _____

Telephone: (____) _____ Mobile: (____) _____

Date of Birth (mm/dd/yyyy): _____ Sex (circle): M F Email: _____

Applicant Status (please check one): Person with Epilepsy Family Member Caregiver

SCHOOL INFORMATION

Name of Current/Last School Attended: _____

Graduation Date: _____

Address of Current/Last School Attended: _____

City: _____ State: _____ ZIP: _____

Type of School (high school/vocational school/college): _____

Honors and Achievements: _____

FUTURE INSTITUTION (If same as above indicate "same")

Name of College/Vocational School You Will Be Attending: _____

Address: _____

City: _____ State: _____ ZIP: _____

Declared Major (if applicable): _____

Declared Minor (if applicable): _____

Degree You Are Pursuing: _____

Bursar's Info : _____

(If selected, your school's bursar's office is contacted directly)

Bursar's Office Contact: _____ Phone: _____

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(Cont'd)

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(Section 1 cont'd)

Please enter my application in the 2012 UCB Family Epilepsy Scholarship Program™. I understand that the selection of a student will be at the sole discretion of the Selection Committee chosen by UCB, Inc.

By signing below, I certify that all information contained in this application is true and accurate, and I authorize UCB, Inc. to publish, copyright, and use any and all information contained in this application, including photographs, in advertising and other promotional materials, including, but not limited to, display on the Internet on any of the UCB-owned websites.

Signature: _____ Date: _____

Parent/Guardian Permission (if applicant is less than 18 years of age): I acknowledge that I am the parent or legal guardian of the applicant and, in that capacity, I certify that all information contained in this application is true and accurate, and I authorize UCB, Inc. to publish, copyright, and use any and all information contained in this application, including photographs, in advertising and other promotional materials, including, but not limited to, display on the Internet on any of the UCB-owned websites.

Parent/Guardian Signature: _____ Date: _____

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Contact us at UCBScholarship@hudsongloballlc.com or 866-825-1920 for additional information or answers to questions.

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SECTION 2: TO BE COMPLETED BY SCHOOL OFFICIAL

A. Instructions for Applicant: This section should be completed by a school official. No parent recommendation letters will be accepted. If you have been out of school for an extensive time period or are home schooled, please obtain a letter of recommendation from an alternate source. NOTE: An original copy of your academic transcript must be received by April 20, 2012, for your application to be complete.

B. Instructions for School Official: The recommendation you provide is for an applicant of the UCB Family Epilepsy Scholarship Program™. The purpose of this scholarship program is to provide financial support for the education of people living with epilepsy, including patients, family members, and caregivers. UCB, Inc. seeks to recognize the personal achievements of those people living with epilepsy. Thirty one-time scholarships will be awarded to people living with epilepsy, and to family members or caregivers of people living with epilepsy, for use toward tuition at a United States-based center for higher learning (trade school, associate’s, bachelor’s, master’s degree, etc).

APPLICANT INFORMATION (Please Print or Type)

Name: _____

Permanent Home Address (no PO boxes): _____

City: _____ State: _____ ZIP: _____

Telephone: (____) _____ Mobile: (____) _____

Date of Birth (mm/dd/yyyy): _____ Sex (circle): M F Email: _____

Applicant Status (please check one): Person with Epilepsy Family Member Caregiver

NOTE TO APPLICANT:

If you are not currently enrolled in high school/college or are home schooled, please provide a one-page letter of recommendation from an alternate official (eg, employer, community member, or healthcare provider) in lieu of an official school recommendation.

REQUIRED RECOMMENDATION FROM SCHOOL OFFICIAL

This letter of recommendation can come from a teacher, professor, guidance counselor, registrar, school nurse, principal, dean, or any other employee of the school. Please provide a one-page letter of recommendation that expresses:

- The nature of your relationship with the student
- The student’s unique qualities
- How the student has positively dealt with epilepsy as part of his or her life

Please send application and all letters of recommendation postmarked by April 20, 2012, to:

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120 White Plains Road, 2nd Floor
Tarrytown, NY 10591

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SECTION 3: TO BE COMPLETED BY COMMUNITY MEMBER

A. Instructions for Applicant: This section should be completed by a community member (employer, clergy, etc.)

B. Instructions for Community Member: The recommendation you provide is for an applicant of the UCB Family Epilepsy Scholarship Program™. The purpose of this scholarship program is to provide financial support for the education of people living with epilepsy, including patients, family members, and caregivers. UCB, Inc. seeks to recognize the personal achievements of those people living with epilepsy. Thirty one-time scholarships will be awarded to people living with epilepsy, and to family members or caregivers of people living with epilepsy, for use toward tuition at a United States-based center for higher learning (trade school, associate's, bachelor's, master's degree, etc).

APPLICANT INFORMATION (Please Print or Type)

Name: _____

Permanent Home Address (no PO boxes): _____

City: _____ State: _____ ZIP: _____

Telephone: (____) _____ Mobile: (____) _____

Date of Birth (mm/dd/yyyy): _____ Sex (circle): M F Email: _____

Applicant Status (please check one): Person with Epilepsy Family Member Caregiver

REQUIRED RECOMMENDATION FROM COMMUNITY MEMBER

Please provide a one-page letter of recommendation that expresses:

- The nature of your relationship with the applicant
- The applicant's unique qualities
- How the applicant has positively dealt with epilepsy as part of his or her life

Please send application and all letters of recommendation postmarked by April 20, 2012, to:

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SECTION 4: TO BE COMPLETED BY HEALTHCARE TEAM MEMBER (Only this form needs to be completed, full medical history is not required but is accepted)

A. Instructions for Applicant: The healthcare team includes physicians, nurse practitioners, physician’s assistants, nurses, social workers, or any certified practitioner who is directly involved in the medical care of the patient living with epilepsy. If the applicant is a family member of, or caregiver to, someone living with epilepsy, this section should be completed by the healthcare team member that cares for the patient living with epilepsy. If you are a family member or caregiver applying, the recommendation letter can come from an alternate source but the Medical History form below is still required.

B. Instructions for Healthcare Team Member: The individual listed below is applying for the UCB Family Epilepsy Scholarship Program™. The purpose of this scholarship program is to provide financial support for the education of people living with epilepsy, including patients, family members, and caregivers. UCB, Inc. seeks to recognize the personal achievements of those people living with epilepsy. Thirty one-time scholarships will be awarded to people living with epilepsy, and to family members or caregivers of people living with epilepsy, for use toward tuition at a United States–based center for higher learning (trade school, associate’s, bachelor’s, master’s degree, etc).

APPLICANT INFORMATION (Please Print or Type)

Name: _____

Permanent Home Address (no PO boxes): _____

City: _____ State: _____ ZIP: _____

Telephone: (____) _____ Mobile: (____) _____

Date of Birth (mm/dd/yyyy): _____ Sex (circle): M F Email: _____

Applicant Status (please check one): Person with Epilepsy Family Member Caregiver

PATIENT INFORMATION:

To be completed by the healthcare team member caring for the person with epilepsy.

Name: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth (mm/dd/yyyy): _____ Sex (circle): M F

PATIENT’S MEDICAL HISTORY

1. I certify that this patient has been diagnosed with epilepsy (check one): Y N
 2. Please provide the date on which this diagnosis was made (mm/dd/yyyy): _____
 3. Indicate the patient’s form of epilepsy: _____
 4. Please share any additional comments regarding the patient’s medical history: _____
- _____
- _____
- _____

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BE SURE TO COMPLETE AND POSTMARK APPLICATION BY THE DEADLINE OF APRIL 20, 2012. (Cont’d)

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(Section 4 cont'd)

I certify that this patient is under my medical care for epilepsy.

Your Name (Please Print or Type): _____ Phone: (____) _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Signature: _____ Credentials: _____ Date: _____

Nature of the Relationship of Patient to the Applicant (self/brother/sister/parent, etc): _____

REQUIRED RECOMMENDATION FROM HEALTHCARE TEAM MEMBER

I will be providing a recommendation for the applicant

I will not be providing a recommendation for the applicant

If you will not be providing a recommendation, please notify the applicant that they must obtain a letter of recommendation from an alternate source to be considered (school official, community member, etc).

Please provide a one-page letter of recommendation that expresses:

- The severity of the ***patient's*** form of epilepsy, including seizure type and frequency
- The nature of your relationship with the ***applicant***
- The ***applicant's*** unique qualities
- The impact epilepsy has had on the ***applicant's*** daily activities
- How the ***applicant*** has positively dealt with epilepsy as part of his or her life

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