

**DEADLINE: MARCH 5, 2018**

**SECTION 4: TO BE COMPLETED BY HEALTHCARE TEAM MEMBER**

**(Full medical history is not required but is accepted.)**

**A. Instructions for Applicant:** The healthcare team includes physicians, nurse practitioners, physician 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 who cares for the patient living with epilepsy. If you are a family member or caregiver applying for a scholarship, you may obtain a recommendation letter 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 impacted by epilepsy, including patients, family members, and caregivers. UCB, Inc. seeks to recognize the personal achievements of those people impacted by epilepsy. Thirty-two 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: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Primary Telephone: (\_\_\_\_) \_\_\_\_\_ Alternate Telephone: (\_\_\_\_) \_\_\_\_\_  
Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Sex (please check one):  Male  Female  
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 (Please Check One):  Male  Female

**PATIENT'S MEDICAL HISTORY:**

1. I certify that this patient has been diagnosed with epilepsy (check one):  Yes  No
2. Please provide the date on which this diagnosis was made (mm/dd/yyyy): \_\_\_\_\_
3. Indicate the patient's form of epilepsy: \_\_\_\_\_
4. Current therapies for epilepsy: \_\_\_\_\_  
\_\_\_\_\_
5. Please share any additional comments regarding the patient's medical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact us at [ucbepilepsyscholarship@summitmedcomm.com](mailto:ucbepilepsyscholarship@summitmedcomm.com) or 1-866-825-1920 for additional information or answers to questions.

**BE SURE TO COMPLETE AND POSTMARK YOUR APPLICATION BY THE DEADLINE OF MARCH 5, 2018.**

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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

**Please send application and all letters of recommendation postmarked by March 5, 2018, to:**

UCB Family Epilepsy Scholarship Program™  
c/o Summit Medical Communications  
1421 E. Broad Street, Suite 340  
Fuquay-Varina, NC 27526

Contact us at [ucbepilepsyscholarship@summitmedcomm.com](mailto:ucbepilepsyscholarship@summitmedcomm.com) or 1-866-825-1920 for additional information or answers to questions.

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