2021 APPLICANT AGREEMENT:

I hereby affirm that all information provided by me in my submission is true and correct to the best of my knowledge. I also consent that if chosen as a scholarship winner my picture may be taken and used to promote the InfuCare Rx Scholarship program.

I hereby understand that if chosen as a scholarship winner, according to the InfuCare Rx Scholarship policy, it is my responsibility to use all scholarship funds toward furthering the education through private or public college/university listed above. I also agree to be an ambassador for this scholarship program in the upcoming year and will conduct myself accordingly.

I hereby understand that I will not submit this application without all required attachments and supporting information. Incomplete applications or applications that do not meet eligibility criteria will not be considered for this scholarship.

Signature of scholarship applicant: ___________________________________

Date: _______________

STATEMENT BY PHYSICIAN

I hereby affirm that this application meets the criteria set forth by the InfuCare Rx Scholarship program.

I hereby affirm that ________________________ (name of applicant) has been diagnosed with ____________________________, and that I oversee this patient.

Signature of physician submitting the application: _________________________________

Date: _______________

Contact information (email and phone): ____

Clinic or hospital name: ____

Revised 1/05/2021