



**2023 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 selected as a scholarship recipient, the photo and answers I submit in my application may be used by InfuCare Rx for marketing purposes 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 my education through the private or public college/university referred to in my application.

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 PRACTITIONER**

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.

**Name of Practitioner:** \_\_\_\_\_

**Signature of Practitioner:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Contact Information (email/phone):** \_\_\_\_\_

**Clinic or hospital name:** \_\_\_\_\_