2024 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: ____

Revised 1/10/2024