2017-2018 PEDIATRIC COLLEGE SCHOLARSHIP PROGRAM APPLICATION

TO: Pediatric College Scholarship Program Applicant

Thank you for your interest in applying to the Pediatric College Scholarship Program. The scholarship provides one-time financial support to students attending undergraduate (four-year) college/university, community college, or vocational/technical school.

This scholarship application is available to students who have been treated for a minimum of 3 months at MD Anderson Cancer Center or comprehensively treated on a pediatric protocol at MD Anderson Cancer Center. This includes students currently undergoing treatment and/or students who no longer require medical treatment. In order to be considered for this scholarship, each applicant must meet the eligibility criteria outlined on the website.

Application Instructions

Deadline: September 20, 2017
Incomplete applications and/or applications postmarked after September 20, 2017 will NOT be accepted

Submission Address: Andrea Warren
MD Anderson Cancer Center
1515 Holcombe Blvd. – Unit 115
Houston, TX 77030
PediatricScholarships@mdanderson.org

Applications must include the following before mailing:

☐ Application, pages 2-5 completed
  ☐ Part I: APPLICANT INFORMATION
  ☐ Part II: ACADEMIC INFORMATION
  ☐ Part III: MEDICAL UPDATE
  ☐ Part IV: ACKNOWLEDGEMENT with applicant signature
  ☐ Part V: AUTHORIZATION FORM with applicant signature

☐ Official transcript(s) in an un-opened envelope sealed by the school’s registrar
  • All community college and/or four-year college/university attended
    o Must include classes currently enrolled in for the 2017-2018 academic year
    o Must include grades for past semesters
  • If you are an incoming freshman, please include a high school transcript

☐ Essay – Please relate a specific example of how your cancer experience and/or being treated at MD Anderson has influenced your academic career, volunteer work, career path or personal relationships.
*Technical/Vocational applicants may submit two letters of recommendation in place of essay
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Part I: APPLICANT INFORMATION

Applicant's Name: ________________________________________________________________

Last    First    Middle                   Maiden

Applicant’s Phone number: _____________________    E-mail address: ________________________________________________

Permanent
Address: ________________________________________________________________

Number & Street__________________________________________________________________________________________________

City      State    Zip Code          Country

Age: ___________    Date of Birth: ___________________________    Gender (please check): □ Male    □ Female

Part II: ACADEMIC INFORMATION

What type of scholarship are you seeking?    □ Four-year College / University    □ Community College    □ Technical/Vocational

Please list schools that you have attended, type of school (four-year college/university, community college, graduate school, or vocational/technical school).

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Type of school</th>
<th>cumulative grade point average (GPA)</th>
<th>Degree earned</th>
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If you have taken the following standardized tests, please list your scores:

_____ SAT     _____ IELTS     _____ GRE     _____ LSAT

_____ ACT     _____ TOEFL     _____ GMAT     _____ MCAT

What type of school are you currently enrolled in?

□ High school    □ Vocational/Technical school    □ Community college    □ Four-year College / University

□ Graduate school    □ Not enrolled

What college/university/school will you attend in the fall of 2017? ________________________________________________

What will your college grade level be in September 2017?

□ Freshman    □ Sophomore    □ Junior    □ Senior    □ Graduate    □ Vocational    Other _______________________________________

What is your certification, major and/or course of study? ________________________________________________________

What is your anticipated graduation date (month and year)? ________________________________________________________
Part III: MEDICAL UPDATE

All information on this application will remain confidential and will be viewed by Pediatric College Scholarship Program Committee members only.

Medical Diagnosis: ___________________________________________________________ Date of Diagnosis: ____________

Treatments (please check all treatments that you have received and/or are currently receiving)

- Surgery
- Radiation Therapy
- Chemotherapy
- Bone Marrow Transplant/Stem Cell Transplant
- Other: ____________________________________________________________________

MD Anderson Cancer Center Medical Record Number: _____________________________

Are you currently being treated for this diagnosis? ____________ If no, when did you finish treatment? ______________
If yes, where do you currently receive medical treatment? ________________________________________________

The Pediatric College Scholarship Program Committee considers the amount of physical hardship applicants have experienced as the result of having a cancer diagnosis and side effects from medical treatment. If there have been follow-up treatments at facilities other than MD Anderson Cancer Center, please explain below:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you had any treatment for relapse or reoccurrence of cancer? If so, please explain when you received treatment and what type of treatment you had.

______________________________________________________________________________
______________________________________________________________________________
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Please use the space below if you would like to add information regarding your medical treatment for the committee to review. This could include how your medical condition effected your academic progress.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Please check any of the following support services and/or activities you have participated in at MD Anderson Cancer Center:

- Children’s Art Project
- Pediatric School Program
- Psychology Services
- Camp Star Trails
- Clinical Research Studies
- Physical/Occupational Therapy (PT/OT)
- Camp AOK
- Child Life Program
- Childhood Cancer Survivorship Clinic

Please check any of the following conditions you have experienced due to your diagnosis and/or treatment.

- Amputation or limb salvage
- Convulsions
- Joint or hip damage
- Facial or visible scars
- Hearing loss
- Breathing problems
- Difficulty swallowing
- Loss of vision
- Difficulty concentrating
- Excessive weight gain or loss
- Pain
- Weakness that makes use of hands or legs difficult
- Learning disabilities
- Hormone deficits
- Graft versus Host Disease (after transplant)
- Excessive fatigue
- Heart problems
- Osteoporosis (weak bones)

Please list any other conditions you have experienced that were not listed above:

_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

Part IV: ACKNOWLEDGEMENT

Please select one of the following statements and sign.

_________ I am a United States citizen and have completed parts I through V of this application, and have enclosed official transcripts, test scores, medical history, essay, statements, and letters of recommendation (if required), and authorization form.

_________ I am an International applicant and have completed parts I through V of this application, and have enclosed official transcripts, test scores, medical history, essay, statements, letters of recommendation, if required, and an authorization form (all translated into English). Please note: 30% of scholarship award will be deducted to meet tax obligations. If applicable, please provide proof of your VISA stamp, I-94, I-20 (for F1), and DS-2019 (for J1) to possibly reduce your tax burden.

Applicant Signature _____________________________________   Date ____________________________

If under 18, please print name of parent or legal guardian ________________________________________________

Guardian
Signature ____________________________________         Date __________________________________
Part V: AUTHORIZATION FORM

Pediatric College Scholarship Program Authorization Form
for the Use and Disclosure of Protected Health Information (PHI)

The purpose of this form is to grant permission for The University of Texas MD Anderson Cancer Center to use my protected health information (PHI) for purposes of the Pediatric College Scholarship Program committee. This information will be kept confidential, and reviewed only by the Pediatric College Scholarship Program committee in order to consider a candidate’s qualification for a scholarship. I hereby authorize MD Anderson Cancer Center and specifically the Pediatric College Scholarship Program committee to review and use the following PHI:

- Demographic information (including contact information, age, geographic location)
- Diagnosis, treatment and biographical information
- Future appointment schedules

I understand I may revoke this authorization in writing at any time except to the extent MD Anderson Cancer Center has already relied on this authorization. I understand that in order to revoke this authorization I must send a written notice stating my intent to revoke this authorization to the Associate Vice President of Volunteer Services and Merchandising; MD Anderson Cancer Center; 1515 Holcombe Boulevard, Unit 115, Houston, Texas 77030.

Unless otherwise revoked, I understand that the specific date or event upon which authorization expires at the end of the 2017-2018 academic year.

I understand that participation in the Pediatric College Scholarship Program is voluntary, and I understand that signing this authorization is voluntary, and declining to do so will not affect my health care treatment at MD Anderson Cancer Center.

Name ___________________________________________    Medical Record Number ___________________
Signature _________________________________________    Date __________________________________

If under 18, please print name of parent or legal guardian __________________________________________

Guardian
Signature _________________________________________    Date __________________________________