THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

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: ACKNOWELDGEMENT 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
    - Must include classes currently enrolled in for the 2017-2018 academic year
    - 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

Do Not Staple **Last Name _____**

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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).

Name of School **Type of school** **cumulative grade point average (GPA)** **Degree earned**

_____
_____
_____
_____

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.

_____
_____
_____
_____
_____
_____
_____

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.

_____
_____
_____
_____
_____
_____
_____

Do Not Staple **Last Name _____**

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

- ☐ Children's Art Project
- ☐ Camp Star Trails
- ☐ Camp AOK
- ☐ Pediatric School Program
- ☐ Clinical Research Studies
- ☐ Child Life Program
- ☐ Psychology Services
- ☐ Physical/Occupational Therapy (PT/OT)
- ☐ 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
- ☐ Facial or visible scars
- ☐ Difficulty swallowing
- ☐ Excessive weight gain or loss
- ☐ Learning disabilities
- ☐ Excessive fatigue
- ☐ Convulsions
- ☐ Hearing loss
- ☐ Loss of vision
- ☐ Pain
- ☐ Hormone deficits
- ☐ Heart problems
- ☐ Joint or hip damage
- ☐ Breathing problems
- ☐ Difficulty concentrating
- ☐ Weakness that makes use of hands or legs difficult
- ☐ Graft versus Host Disease (after transplant)
- ☐ Osteoporosis (weak bones)

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

_____

_____

_____

_____

_____

_____

Part IV: ACKNOWELDGEMENT

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

THE UNIVERSITY OF TEXAS
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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 _____