LUCIANA SPRING MASCARIN BURSARY PROGRAM

Named in honour of
Luciana Spring Mascarin

established, supported and directed by
The Spina Bifida and Hydrocephalus Association of Ontario

2018 APPLICATION FORM

Only Windsor-Essex & Chatham-Kent area residents are eligible to apply for this bursary.

This is an application form for a bursary administered by the Spina Bifida and Hydrocephalus Association of Ontario. To ensure that you will be considered for this bursary, please answer all of the questions carefully. All information supplied on this form will be considered by the committee. Falsification of any information will result in automatic rejection of the application.

Forward two copies of the completed application form by **the last business day in March annually** to:

SPINA BIFIDA & HYDROCEPHALUS ASSOCIATION OF ONTARIO
Luciana Spring Mascarin Bursary Program
16 Four Seasons Place, Suite 111
Toronto, Ontario M9B 6E5
email: provincial@sbhao.on.ca
fax: 416-214-1446

If you fax or e-mail your application you must also submit the original documents by mail.

Please print or type all information.

Name: ____

Mailing Address: ____

____

Postal Code: ____________________ Telephone #: ____________________

Home Address: ____

____

Email Address: ____

Date of Birth: ____

Name of the university, college or other educational facility you plan to attend this fall. Please enclose evidence of acceptance or forward that evidence when you receive it.

____

____

Proposed course of study:

____

____

State your future educational and career objectives.

____

____

Name other scholarships or bursaries which you expect to receive this year or for which you have applied, this year.

		will receive	**have applied**
Name: ____________________	Amount: $ __________	☐	☐
Name: ____________________	Amount: $ __________	☐	☐
Name: ____________________	Amount: $ __________	☐	☐

Name any scholarships, awards, bursaries, medals or certificates of recognition that you have previously received (with dates).

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Estimate the total cost of your education for the next year.

Tuition ______________________ Residence ______________________

Books ______________________ Travel ______________________

Specialized Equipment/Services ______________________

Other (specify) ______________________

Are you receiving:

	YES	**NO**
Ontario Disability Support Benefits	☐	☐
Student Loans/Grants	☐	☐

Have you applied for:

	YES	**NO**
Ontario Disability Support Benefits	☐	☐
Student Loans/Grants	☐	☐

State how you expect to finance your education:

____

____

____

List your employment history, including full-time, part-time and summer jobs, co-op placements and volunteer work, with dates.
Employment:

____

____

____

____

____

Co-op Placements:

Work Experience Program:

Mandatory Volunteer Work (eg. 40 hours for high school graduation):

Other Volunteer Work:

List your hobbies and special interests.

IMPORTANT

Two copies of this application form plus the following documents must be received in the Spina Bifida and Hydrocephalus Association of Ontario offices by **the last business day of March Annually.**

If you fax or e-mail these documents you must also submit the originals by mail.

- ☐ Academic transcript (include the most recently completed semester)
- ☐ The medical assessment form (not required if you have previously applied unless your situation has changed)

Applications received after the last business day of March cannot be considered.

I affirm that the information in this application is correct and complete.

Date: ____________________ Signature: ______________________________