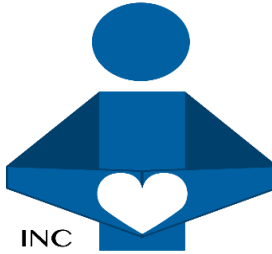


**CONNECTICUT GI  
CHARITABLE  
FOUNDATION**



INC

**CONNECTICUT GI CHARITABLE FOUNDATION SCHOLARSHIP  
PROOF OF DIAGNOSIS FORM**

**This section to be completed by Scholarship Applicant**

Applicant Name: \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State \_\_\_\_\_ Postal Code: \_\_\_\_\_

Office telephone: \_\_\_\_\_

Health Care Provider E-mail (if applicable): \_\_\_\_\_

**This section to be completed by Scholarship Applicant**

I give permission for my clinician to complete this application for the purposes of a scholarship application:

Applicant Signature \_\_\_\_\_

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**This section to be completed by Health Care Provider**

I certify that this applicant is under my medical care and has been diagnosed with:

- Crohn's disease
- Ulcerative colitis
- Liver disease. Please specify \_\_\_\_\_
- Other disease affecting the GI tract. Please specify \_\_\_\_\_

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Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Credentials: \_\_\_\_\_

