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___________________________________

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 _________________________

Provider Signature:_____________________________Date:____/____/_____

Credentials: ____