Children's Hemiplegia and Stroke Association
Education Scholarship Application
(April 2013 Revision)

CHASA is proud to offer an annual scholarship for those affected by childhood hemiplegia. Scholarship envelope should be postmarked by August 31st of each year. Please read the scholarship guidelines below to determine your eligibility.

Eligibility requirements

- Age 25 years or less
- Affected by either childhood hemiplegia or hemiparesis due to any cause or by pediatric stroke, Onset of condition before the age of 18. Currently diagnosed as having hemiplegia or hemiparesis or pediatric stroke
- Attending a post-secondary school leading to a degree or certification or attending a post-secondary vocational education program
- You may reapply for consideration each year for up to four consecutive years
- If you have been awarded a CHASA scholarship, you may reapply for consideration for up to a total of four years
- You must be enrolled in college for the Fall of the year in which you apply.

Application requirements

- Application form (page two of this packet)
- Essay (page three of this packet)
- Physician's signature on the certifying form (page four of this packet). THIS MUST BE MAILED DIRECTLY BY THE PHYSCIAN IN THE PHYSICIAN'S OFFICE-STATIONERY ENVELOPE OR ENVELOPE STAMPED WITH THE PHYSICIAN'S RETURN ADDRESS. Please do not mail in a standard envelope. If this Physician Statement page is mailed by you and not the doctor, we will not be able to consider your application.
- Permission to release name/image (page five of this packet)
- All required elements postmarked by August 31st of the application year
- All application material is confidential unless the release is signed and the property of the Children's Hemiplegia and Stroke Association.

Scholarship information

- The number of scholarships awarded per year will be determined by the board on an annual basis depending on funds
- The amount of each scholarship will vary from year to year as determined by the board.
- Recipient(s) will be notified by October 31st of the application year and scholarship check will be delivered to the school

Mailing address:
4101 W. Green Oaks,
Suite 305, #149
Arlington, TX 76016
Email questions to: info437@chasa.orgIf you have questions, please utilize email instead of phone since CHASA has a limited number of volunteers who answer the phone.

CHASA COLLEGE SCHOLARSHIP APPLICATION

Please print or type

Name**:**_____ Birth date: _____

Address: _____

_____

Phone: (_____)_____ Email: _____
Note regarding email: Please **carefully print** email. This is how we will communicate with you. If there are unusual characters in your email, like a "1" or "l" (number 1 or lower case letter L), please help us understand this character so we can reach you.

Guardian's name (if under age 18): _____

Name & address of high school or last school attended: _____

_____

Name and address of school you will be attending the coming year: _____

_____

Degree you will be working toward (if known): _____

Will you be attending school _____ Full time _____Part time

Current Grade Level: _____Last semester's GPA and dates: ____
Final High School GPA: _____

List academic achievements/awards: _____
_____
_____

List community or social achievements/awards: _____
_____
_____

Name of physician who will submit Physician Statement: _____

How did you find out about the CHASA scholarship?_____

Applicant's Signature _____ Date _____

Guardian's Signature (if under 18) _____

CHASA SCHOLARSHIP APPLICATION ESSAY

Please print or type

Please answer the following questions. You may use extra paper if needed.

What goals have you set for your future? What experience do you feel has prepared you most for obtaining these goals?

Children's Hemiplegia and Stroke Association
Scholarship Application Physician Statement

Applicant must have his or her physician sign the below statement confirming eligibility for the scholarship. **This must be mailed by the physician in the physician's office-stationery envelope or envelope stamped with physician's return address.** *Mail separately from the main application. Physician statements mailed from your home address will not be accepted. Thank you for your assistance.*

Mail to:
Children's Hemiplegia and Stroke Association
4101 W. Green Oaks, Suite 305, #149
Arlington, TX 76016

I have examined _____
(applicant's name)

and confirm that he/she has experienced hemiplegia or hemiparesis with onset before the age of 18 years and that the applicant currently exhibit hemiplegia or hemiparesis.

Date of onset of hemiplegia or hemiparesis: _____

Cause of hemiplegia or hemiparesis: _____

Applicant currently exhibits hemiplegia or hemiparesis (circle one): yes no

Physician Signature _____ MD/DO

Address_____

_____

Phone _____

Date _____

I, _____ give my physician permission to release the above information to the Children's Hemiplegia and Stroke Association.

Signature of applicant _____

CHASA
Children's Hemiplegia and Stroke Association

Children's Hemiplegia and Stroke Association Scholarship Application
Consent to Release Information

By signing below I am giving CHASA permission to release my name (first and last), state of residence and essay answers either in excerpt or wholly for publicity purposes, including but not limited to the www.chasa.org website or any other CHASA owned website, CHASA print material, and in press releases relating to the scholarship event or Childhood Stroke Awareness Day. I understand that CHASA will not release my address, birth date or other personal information.

Name _____ Date _____