DEADLINE: March 15, 2025

SECTION 4: TO BE COMPLETED BY HEALTHCARE TEAM MEMBER

(Full medical history is not required but is accepted.)

A. Instructions for Applicant: The healthcare team includes physicians, nurse practitioners, physician assistants, nurses, social workers, or any certified practitioner who is directly involved in the medical care of the patient living with epilepsy. If the applicant is a family member of, or caregiver to, someone living with epilepsy, this section should be completed by the healthcare team member who cares for the patient living with epilepsy. If you are a family member or caregiver applying for a scholarship, you may obtain a recommendation letter from an alternate source but the Medical History form below is still required.

B. Instructions for Healthcare Team Member: The individual listed below is applying for the UCB Family Epilepsy Scholarship Program™. The purpose of this scholarship program is to provide financial support for the education of people impacted by epilepsy, including patients, family members, and caregivers. UCB, Inc. seeks to recognize the personal achievements of those people impacted by epilepsy. Thirty-three one-time scholarships will be awarded to people living with epilepsy, and to family members or caregivers of people living with epilepsy, for use toward tuition at a United States–based center for higher learning (trade school, associate's, bachelor's, master's degree, etc.).

APPLICANT INFORMATION (Please Print or Type)

Name: _____

Permanent Home Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

Primary Telephone: _____ Alternate Telephone: _____

Date of Birth (mm/dd/yyyy): _____ Sex (please check one): ❑ Male ❑ Female

Applicant Status (please check one): ❑ Person with Epilepsy ❑ Family Member ❑ Caregiver

PATIENT INFORMATION:

To be completed by the healthcare team member caring for the person with epilepsy. You may write "same as above" if the patient is also the applicant.

Name: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth (mm/dd/yyyy): _____ Sex (Please Check One): ❑ Male ❑ Female

PATIENT'S MEDICAL HISTORY:

1. I certify that this patient has been diagnosed with epilepsy (check one): ❑ Yes ❑ No
2. Please provide the date on which this diagnosis was made (mm/dd/yyyy): _____
3. Indicate the patient's form of epilepsy: _____
4. Current therapies for epilepsy: _____

_____

5. Please share any additional comments regarding the patient's medical history: _____

_____

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(Section 4 cont'd)

I certify that this patient is under my medical care for epilepsy.

Your Name (Please print or Type): _____ Phone: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Signature: _____ Credentials: _____

Nature of the Relationship of Patient to the Applicant (self/brother/sister/parent, etc.): _____

REQUIRED RECOMMENDATION FROM HEALTHCARE TEAM MEMBER:

❑ I will be providing a recommendation for the applicant

❑ I will not be providing a recommendation for the applicant

If you will not be providing a recommendation, please notify the applicant that they must obtain a letter of recommendation from an alternate source to be considered (school official, community member, etc.).

Please provide a one-page letter of recommendation that expresses:

- The severity of the patient's form of epilepsy, including seizure type and frequency
- The nature of your relationship with the applicant
- The applicant's unique qualities
- The impact epilepsy has had on the applicant's daily activities
- How the applicant has positively dealt with the epilepsy as part of his or her life

Please send application and all letters of recommendation postmarked by March 15, 2025 to:
UCB Family Epilepsy Scholarship Program™ c/o Summit Medical Communications
1441 E. Broad Street, Suite 340
Fuquay-Varina, NC 27526

Contact us at ucbepilepsyscholarship@summitmedcomm.com or 1-866-825-1920 for additional information or answers to questions.

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