



Scholarship Application

Scholarships awarded by the Legacy Brain Foundation are not based on need or merit, but are awarded to patients and children of patients who have been diagnosed with a primary or metastatic brain or spinal cord tumor. The Legacy Brain Foundation recognizes that the diagnosis of a tumor often creates a stressful environment for the student, and that financial assistance may be beneficial for students. The award is available for fall and spring semesters, (twice a year) and is limited to \$1,000 per semester, regardless of tuition or need. Students who have previously received an award are encouraged to re-apply, up to a maximum of four years, but are only required to submit an essay once. Scholarship funds are limited to availability, students who have never received assistance, and those whose parent is deceased, have priority in scholarship distribution if funds are limited. Scholarships are limited to residents of Texas or residents of other states who are attending colleges/universities in Texas.

Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone: _____ **Email:** _____

Date of Birth: _____

Current School You Are Attending: _____

GPA: _____ **Graduation Date:** _____

Phone: _____ **Email:** _____

Name of Institution You Plan to Attend: _____

Have you applied to the school? Yes No **Have you been accepted?** Yes No

What is your planned major or field of study? _____

Name of parent with brain or spinal tumor diagnosis: _____

What is their diagnosis? _____

Who is their physician? _____
Name and Specialty Phone Number

Physician Address: _____
Street City State Zip

Signature of Parent: _____

The following documents MUST be submitted to the Legacy Brain Foundation board:

1. Completed and signed application.
2. 500-700 word, typewritten essay on “What Impact Has Brain Cancer Had On My Life” or “My Hope for the Future: How Brain Cancer Has Affected My Career Choice”
3. Official high school or college transcript
4. College / Trade School letter of acceptance if applicable

CERTIFICATION STATEMENT:

I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize the Legacy Brain Foundation to obtain necessary information from the contacts listed in the application that might be helpful for assessing the application. I release the Legacy Brain Foundation of all liabilities or claims arising out of the donation of money or services provided to me or my family.

All information in the application is strictly confidential and will be used only to ascertain eligibility for the scholarship. This information will not be released to any person or persons not associated with the Legacy Brain Foundation board.

Applicants Name (please print): _____

Signature: _____ **Date:** _____

RETURN COMPLETED APPLICATION TO:

Legacy Brain Foundation, Attn: Scholarship Application
Medical City Dallas Hospital
7777 Forest Lane, Suite C-648
Dallas, TX 75230

Or fax to (972) 566-2625

Although not required, we would like to use, in whole or in part, your essay in newsletters, brochures, the website and other media for the Legacy Brain Foundation. **If you do not wish to allow use of your essay, this will not affect your application.**

- Yes, you may use as is.
- No, please do not use at all.
- Yes, but I would like to edit prior to use.

Should you receive a scholarship from the Legacy Brain Foundation, would you be willing to provide a statement, photograph or other information to be used in the LBF media describing the mission of the foundation? **This is strictly voluntary and will not affect your application.** No information of any kind will be used without your consent. Should you choose to do so, information can be sent to info@legacybrainfoundation.org.

- Yes
- No
- I do not wish to answer at this time, but may be open to it in the future.
- Please contact me. I would like more specific information.