THE WOMEN'S BOARD OF THE CENTRAL OHIO DIABETES ASSOCIATION
COLLEGE SCHOLARSHIP FUND
APPLICATION CHECKLIST

Please ensure the following documents are included in your application packet.

Without all of these documents your application will not be complete and will not be accepted for consideration.

_____ Completed Application Form
- If in High School, attach transcripts

_____ Proof of Acceptance (or current attendance) to college or vocational school

_____ One Recommendation Form to non-relative reference.

*Please note: Your reference must mail this form back to the Central Ohio Diabetes Association office separately. You may want to provide them with a stamped envelope. Do not forget to write your name on the top of the form.

_____ Medical Information (completed by Doctor)

* Please note: You must provide permission to your doctor to release medical information (if under 18 your parents must sign). Please complete and sign the top of the medical information form. Your doctor must mail this form to the Central Ohio Diabetes Association office. You may want to provide a stamped envelope.

_____ Statement of Financial Need
First Year Expenses (on back side of Financial Need)

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APPLICATION FORM

I. PERSONAL INFORMATION

Name_____

Address_____

City_____ State_____ Zip_____

Phone #_____ Date of Birth_____

Cell phone #_____ Email _____

If currently in High School complete entire application. If already attending college, skip to section III

II. High School Attended_____ Graduation Date_____

Cumulative GPA:_____ Rank in class_____

Total SAT Score:_____ Composite ACT Score:_____

Attach transcripts.

Attach proof of acceptance to college or college/vocational school you will be attending.

Guidance Counselor Signature_____ Phone_____

III. Field of Study_____ General Career Goal_____

Date of proposed/entrance to college:_____

Name of College/vocational school_____
Anticipated program completion or graduation date_____
If already attending college fill in your college GPA:_____

Date of Diabetes Diagnosis_____

Physician's Name_____
(Diabetes Care Provider)

Address_____ Phone_____

Please give the accompanying medical information form to your physician

IV. PARTICIPATION

Please list and indicate nature of involvement in (include office held and academic honors):

A. High School **or** College/Vocational School Activities:

B. Community Activities (such as church involvement, volunteer work, social services, Central Ohio Diabetes Association or other diabetes awareness, etc.)

V. WORK EXPERIENCE

Business Title Duties Hours Worked Salary

_____

_____

_____

_____

VI. REFERENCE: Please provide name and complete address and phone number (Reference should be supervisor, teacher, coach, employer, minister, etc.; no relatives)

Name_____ Address _____Phone ( )_____
***Please give the attached recommendation form to the person you listed above.**

To my knowledge all the above information is accurate.

Signature of Applicant_____ Date_____

VII. Personal Statement - Answer each of the following questions completely and concisely in 50 words or less.

A. Please describe your experience in living healthy with diabetes. Include contributions to diabetes awareness in your community and any obstacles you've overcome in regards to living with diabetes.

B. Describe in detail what advice you would give a 15 year old teen who has recently been diagnosed with diabetes and how he/she should manage it.

C. What were the specific reasons you chose the college(s) you applied to.

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RECOMMENDATION

_____ is a candidate for a scholarship to pursue post high school training. Your name was given as someone willing and able to provide reference information. Please complete the questions below.

Please describe this individual as you know him/her.

Do you feel this individual shares his/her talents and abilities with others? (Please provide examples if possible).

Do you feel this individual is committed to completing his/her educational plans?

To the best of your knowledge, please describe this candidate's control of his/her diabetes and attitude toward self-care and living with a chronic condition.

Signature_____ Date_____

Printed Name_____

Position_____ Relation to Candidate_____

Please return by February 22, 2019 to:
Cathy Paessun, Director
Central Ohio Diabetes Association
1100 Dennison Avenue
Columbus, OH 43201

THE WOMEN'S BOARD OF THE CENTRAL OHIO DIABETES ASSOCIATION
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MEDICAL INFORMATION

Authorization is hereby granted to _____
Your Doctor's Name

to release information regarding _____diabetes care.
Candidate's Name

_____ _____
Candidate's Signature Date

_____ _____
Parent's Signature (if candidate if under 18) Date

Dear Physician:
The Central Ohio Diabetes Association Women's Board provides a scholarship fund for young adults with diabetes pursuing post high school training. In our attempt to evaluate each candidate we feel it is important to know about the individual's diabetes control and how they cope with living with a chronic condition. Using the following scale, please rate the statements below.
1-NEVER 2-SELDOM 3-SOMETIMES 4-OFTEN 5-ALWAYS

Takes responsibility for self-care. 1 2 3 4 5

Displays positive attitude toward diabetes. 1 2 3 4 5

Is compliant with glucose monitoring, medications and/or insulin dosage and injections.
1 2 3 4 5

Consistently follows nutrition plan and exercise guidelines. 1 2 3 4 5

Is able to balance academic or extra-curricular responsibilities/activities without compromising diabetes control. 1 2 3 4 5

Works cooperatively with diabetes management team. 1 2 3 4 5

Insulin Administration Regimen: Syringe Pen Pump

Most recent Hemoglobin A1c: date_____ result_____

Additional comments:

Signature_____ Date_____

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Cathy Paessun, Director, Central Ohio Diabetes Association, 1100 Dennison Ave., Columbus, OH 43201

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STATEMENT OF FINANCIAL NEED
(to be completed by parent or guardian)

Applicant's Name_____

Father's Name_____

Home Address_____

Employer_____ Position_____

Monthly Gross Salary_____

Mother's Name_____

Home Address_____

Employer_____ Position_____

Monthly Gross Salary_____

Number of Dependents living at home_____ Ages_____

How many of the dependents will be in college next year? _____

Please describe any other unusual expenses.

State your reason for seeking scholarship funds for your son/daughter.

Please provide information demonstrating how your child has exhibited exemplary diabetes care and management.

FIRST YEAR EXPENSES
(to be completed by parents and student)

1. Anticipated cost of one full year of school for all the schools you have been accepted to or have applied for acceptance (include tuition, room, board and expenses provided by college admissions office).

   _____

2. How many dollars per year will the family be able to pay towards applicant's college education?

   _____

3. How much can student contribute from savings and earnings per year?

   _____

4. How much does student hope to earn per year while in college?

   _____

5. As of this date has the candidate been awarded any financial assistance? If yes, state the award and value_____ Total value_____

6. Other anticipated loans/financial aid.

   _____

7. Additional information or circumstance.

_____ _____
Signature of Applicant Signature of Parent