

**2019 APPLICANT AGREEMENT:**



I hereby affirm that all information provided by me in my submission is true and correct to the best of my knowledge. I also consent that if chosen as a scholarship winner my picture may be taken and used to promote the FOSRX/FAST scholarship program. Winners will be asked to submit additional photos with scholarship check.

I hereby understand that if chosen as a scholarship winner, according to the FOSRX/FAST Scholarship policy, it is my responsibility to use all scholarship funds toward furthering the education through private or public college/university listed above. I also agree to be an ambassador for this scholarship program in the upcoming year, and will conduct myself accordingly.

I hereby understand I will not submit this application without all required attachments and supporting information. Incomplete applications or applications that do not meet eligibility criteria will not be considered for this scholarship.

**Signature of scholarship applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_

**STATEMENT BY PHYSICIAN**

I hereby affirm that this application meets the criteria set forth by this scholarship program and that I support this application to FOSRX/FAST.

I hereby affirm that \_\_\_\_\_ (name of applicant) has been diagnosed with \_\_\_\_\_, and that I oversee this patient.

**Signature of physician submitting the application:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Contact information (email and phone):** \_\_\_\_\_

**Clinic or hospital name:** \_\_\_\_\_