Colorado Allergy and Asthma Centers, P.C.

Scholarship Application

Founder's Award Scholarship Fund

Application Deadline
June 15th of each year

PLEASE COMPLETE ALL APPLICANT SECTIONS, THEN PASS THE APPLICATION ON FOR COMPLETION BY A SCHOOL REPRESENTATIVE AND YOUR CAAC PHYSICIAN.

Student's Name (Last, First, Middle) _____

Social Security # _____ E-mail address _____

Student's Address _____

City _____ State_____ Zip _____

Telephone _____ Date of Birth _____ Gender _____

Name of School that you will be attending in the fall _____

School Address _____

City_____ State _____ Zip _____

PHYSICIAN SECTION: Please complete and sign.

Patient's Name_____ Age _____

Present CAAC Physician_____How Long a CAAC Patient _____

CAAC Provider Signature _____

APPLICANT SECTION: Please complete and sign.
Note: If you cannot fit all of your accomplishments on this form, please attach a double spaced bulleted list.

Academic Honors and Achievements

High School _____

_____

College _____

_____

Graduate School _____

_____

Extracurricular Club / Student Government Activities (include office held, honors and awards)

High School _____

_____

College _____

_____

Graduate School _____

_____

Community Service and / or Work Experience

High School _____

_____

College _____

_____

Graduate School _____

_____

APPLICANT ESSAY:

The essay helps our Selection Committee learn more about the applicant in a broader, more informal way. The general topic is: **"How has your medical condition & treatment affected your life and what are your academic & career goals?"** Submit an Essay that is **no more than one page**, highlighting achievements, obstacles you have overcome and future goals.

SCHOOL SECTION:

Please have a Principal, Dean, Guidance Counselor / Advisor or Teacher complete the following.

Academic Standings

Applicant's class rank:_____of _____

Applicant's grade point average:_____on a scale of _____

Briefly assess the Applicant's abilities and accomplishments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of school representative_____Title_____Date _____

LETTERS OF SUPPORT:

All applicants must submit at least one Letter of Support from a school representative. You may submit as many as three, from your school or other sources such as an employer, a community official, etc.

Patient Scholarship Application Checklist:

- Application Form
- List of Accomplishments
- Letter(s) of Support
- Official Academic Transcript
- Applicant Essay
- HIPAA Media Release for Minors (under 18 years old) or HIPAA Media Release for Adults

Please make sure all sections of the application are completed and requested documentation stapled to this application.

INCOMPLETE OR LATE APPLICATIONS WILL NOT BE PROCESSED.

FOUR $1,000.00 SCHOLARSHIPS ANNUALLY

Each scholarship is a one-time-only grant. All scholarships will be disbursed directly to the student's college, and must be used for undergraduate/graduate studies. Scholarship will only be paid in the academic year which the reward was given out.

WHO IS ELIGIBLE

All high school seniors who will graduate and college students already enrolled in a graduate or undergraduate program. Previous winners or employees of CAAC and their immediate families are not eligible.

Applicants must:

- Be in good academic standing
- Be a current patient of Colorado Allergy and Asthma for a minimum of 1 year.
- Be a United States citizen
- Be accepted to an accredited US college

HOW TO APPLY

The applicant, the applicant's physician and a representative from your school must complete the attached application form (or a copy of it). The applicant or parent or guardian (if applicant is less then 18 years of age) must sign the Media Release. Application entries must be legible.

Make sure to include additional materials requested for the selection process. All applications must be accompanied by:

- An official academic transcript
- Letter of support (details provided on form)
- Essay (details provided on form)
- Signed HIPAA Media Release for Minors (under 18 years old) or for Adults

Staple all materials together with the application form on top. Mail all material in one package. Any material that is submitted separately will not be accepted. Incomplete applications will NOT be processed, nor will any material be returned.

All applications must be submitted to:
Colorado Allergy and Asthma Centers, P.C.
2014 Caribou Drive Ste 200
Fort Collins, Colorado 80525
ATTN: Stacy Wiseman

WHEN WILL YOU BE NOTIFIED?

A panel compiled of CAAC physicians and employees selects winners after evaluating the candidates. Winners will be notified via phone call and by mail, in the summer of the current year. All decisions are final. For more information, please go to: www.coloradoallergy.com

HIPAA Media Release for Minors (under 18 years old)

I, the undersigned, do hereby grant or deny permission to Colorado Allergy & Asthma Centers, P.C. to use the image/ writings of my child as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, written testimonials, essays, biographies, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, digital images such as those on the Colorado Allergy & Asthma Centers, P.C. website, and on social media platforms (including but not limited to Facebook, Twitter, and Instagram). I do understand that the child's last name will not be used in conjunction with any video or digital images.

D Deny permission to use my child's image at all.

D Grant permission to use my child's image / writings in the following ways (mark all that apply):

- D **Limited usage:** I want my child's image/ writings used within the Colorado Allergy & Asthma Centers, P.C. setting only (not in the larger community – i.e. not outside of the CAAC practice).
- D **Limited usage:** I want my child's image/ writings used for educational materials only (not marketing). This could be either within Colorado Allergy & Asthma Centers, P.C. or in the larger community. One example of this is videos used for parent education classes.
- D **Limited usage:** I want my child's image/ writings used on printed materials only (no digital or video use).
- D **Unrestricted usage:** I give unrestricted permission for my child's image/ writings to be used in print, video, and digital media. I agree that these images may be used by Colorado Allergy & Asthma Centers, P.C. as stated in the above examples and that these images may be used without further notifying me.

Minor Name _____

Parent/guardian printed name _____

Parent/guardian signature _____ Date _____

Witness _____ Date _____

HIPAA Media Release for Adults

I, the undersigned, do hereby grant or deny permission to Colorado Allergy & Asthma Centers, P.C. to use my image/ writings as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, written testimonials, essays, biographies, and/or video taken of me for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, digital images such as those on the Colorado Allergy & Asthma Centers, P.C. website, and social media platforms (including but not limited to Facebook, Twitter, and Instagram). I do understand that my last name will not be used in conjunction with any video or digital images.

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Patient printed name _____

Patient signature _____ Date _____

Witness _____ Date _____