Columbia
COLLEGE CHICAGO

HILLARY R. KALISH SCHOLARSHIP

PHYSICIAN'S STATEMENT

SCHOLARSHIP APPLICATION DUE BY March 1, 2024
PHYSICIAN'S STATEMENT DUE BY March 5, 2024

THE HILLARY R. KALISH SCHOLARSHIP application requires a signed statement from your physician describing your medical challenge and how it will affect your capacity to attend Columbia. Once the physician signs the form, please return it by email, fax, or mail.

EMAIL: scholarships@colum.edu

FAX: 312-369-8436

Attn: Stephanie Schulze

MAIL: Columbia Central
Columbia College Chicago
Attn: Scholarships/Stephanie Schulze
600 S. Michigan Ave., Suite 303
Chicago, IL 60605

PLEASE PRINT OR TYPE ALL INFORMATION

NAME _____ MYCOLUMBIA # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL ADDRESS _____

PERMISSION TO RELEASE MEDICAL INFORMATION

I hereby grant permission for my physician to release, share with, or describe to the Hillary R. Kalish Scholarship Committee at Columbia College Chicago such medical records and/or opinions as he or she deems necessary in order for me to be considered as a candidate for the scholarship. The committee will only use this information to make a determination as to the applicant's eligibility for the scholarship. The committee will not share this information with anyone outside of the committee without the applicant's permission.

STUDENT'S SIGNATURE _____ DATE _____

PHYSICIAN'S STATEMENT

Please describe how this medical condition has affected or will continue to affect the student's capacity to participate in a rigorous college schedule:

PHYSICIAN'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE NAME AND DESCRIBE THE STUDENT'S MEDICAL CONDITION, ILLNESS OR SYNDROME

ADDITIONAL COMMENTS

I understand and agree that my statements above may be shared with appropriate Columbia College Chicago personnel as they consider the student's application for assistance through the Hillary R. Kalish Scholarship Program.

PHYSICIAN'S SIGNATURE _____ DATE _____