

THE BOBBY JONES OPEN SCHOLARSHIP



FOR INDIVIDUALS WITH SYRINGOMYELIA

Please check one:

\_\_\_ January 15 – May 15  
New Application Filing Period

\_\_\_ May 15 – June 15  
Renewal Application Filing Period

**SCHOLARSHIP APPLICATION FOR ACADEMIC YEAR 20\_\_ - 20\_\_**

**Section 1. Applicant Information**

Full name of student \_\_\_\_\_  
Last First Middle Initial

Home address \_\_\_\_\_  
Street Address City State Zip Code

Home area code and telephone number \_\_\_\_ / \_\_\_\_

Are you or your parent a member of American Syringomyelia Alliance Project, INC. (ASAP)? \_\_\_ Y \_\_\_ N  
Member since \_\_\_\_ / \_\_\_\_ / \_\_\_\_ If parent, full name of parent \_\_\_\_\_

**Section 2. Essay Question (If first-time applicant, select one of the topics below.)**

Write an essay of at least one typed page in length to submit with your scholarship application.

- Describe your typical day before and after you were diagnosed with syringomyelia (SM) or chiari malformation (CM).
- Describe how SM or CM has influenced or changed your life and those around you.
- If SM or CM influenced your choice of study and long-range career plans, describe how your study of \_\_\_\_\_ will contribute to your career goal.
- Describe a personal experience when SM or CM was an obstacle to your accomplishing a goal and how you overcame it.

**Section 3. Academic Information**

**First-time Applicant**

College, university, or other postsecondary institution(s) to which you have applied (If you already have received an acceptance for admission, attach a copy of your acceptance notice.):

Expected date of enrollment \_\_\_\_ / \_\_\_\_  
Month Year

Major course of study intended (if known)

Expected Academic Load:  
Full-time \_\_\_\_\_ Half-time \_\_\_\_  
(indicate number of semester or quarter hours)

**Renewal Applicant (based on funds availability)**

Attach an official (certified) academic transcript showing (1) your college courses through all completed academic terms, (2) the credit hours received, and (3) the grade point average to date.

Name and address of college where you are enrolled:

Expected graduation date \_\_\_\_ / \_\_\_\_  
Month Year

Major course(s) of study (If you have not yet declared your major, show those you are most seriously considering.)

Expected Academic Load:  
Full-time \_\_\_\_\_ Half-time \_\_\_\_  
(indicate number of semester or quarter hours)

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## Section 4. Financial Information

### Family Financial Information

If you are a dependent student, what is your

Father's occupation? \_\_\_\_\_

Father's age? \_\_\_\_\_

Mother's occupation? \_\_\_\_\_

Mother's age? \_\_\_\_\_

If you are an independent student, what is your occupation? \_\_\_\_\_

Indicate the total family income (or, if independent, your personal income) for the most recent calendar year (Include all non-taxable and taxable income, before taxes):

\_\_\_ Less than \$20,000

\_\_\_ \$20,000 - \$29,999

\_\_\_ \$30,000 - \$39,999

\_\_\_ \$40,000 - \$49,999

\_\_\_ \$50,000 - \$59,999

\_\_\_ \$60,000 and above

Primary residence: \_\_\_ Owned \_\_\_ Rented

Years lived in this residence: \_\_\_\_\_

Size of household, including parents (if applicable): \_\_\_\_\_

Number to be in college during school year covered by this application: \_\_\_\_\_

### Expected College Costs for Applicant

Expected college cost for applicant for academic year: \$ \_\_\_\_\_ (include tuition, room & board (if applicable), books, and fees)

### Student Financial Aid for Applicant

For what other student financial aid have you applied or will you receive for the academic year covered by this application?

List name(s) and amount(s):

If you are a renewal applicant and have borrowed funds to cover some of your enrollment costs, show the total amount currently outstanding:

\$ \_\_\_\_\_

## Section 5. Physician's Certification (Have this section completed if first-time applicant.)

**Instructions for Physician:** The applicant identified in Section 1 is applying for a scholarship based on his/her or his/her parent's diagnosis with syringomyelia (SM) or chiari malformation (CM). You should complete and sign the certification in this Section 5 only if you are a doctor of medicine or osteopathy legally authorized to practice in the United States and if the applicant or parent, as designated in Section 1, has been diagnosed with SM or CM. Please return this application to the person named in Section 1 after Section 5 has been completed and signed.

I am a doctor of (check one) \_\_\_ medicine \_\_\_ osteopathy legally authorized to practice in the state of \_\_\_\_\_. My professional license number is \_\_\_\_\_. (This information is subject to verification through State records.)

By signing below, I certify that, in my best professional judgment, the applicant or parent identified in Section 1 has been diagnosed with SM or CM.

\_\_\_\_\_  
Physician's Signature (a signature stamp is not acceptable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Address City, State, Zip

*Continued on next page*

## Section 6. Applicant's Affirmation and Authorization for Release of Information

By my signature I affirm that all of the information provided on this application form and any attachments is true and correct to the best of my knowledge; I further affirm that I have not knowingly withheld any information that should have been provided.

By my signature I authorize the college that I will attend to release to College Foundation, Inc. any academic information or information about other student financial aid that I have received or will receive for the academic year covered by this application.

I understand that (1) if I am a first-time applicant and I am selected to receive a Bobby Jones Open Scholarship, I must send to College Foundation, Inc. a copy of my college acceptance letter before the scholarship funds will be released and (2) if I receive a Bobby Jones Open Scholarship, I must maintain enrollment for the academic workload indicated on my application in an eligible college or university for the academic year covered by the award.

Signature (full name) of student \_\_\_\_\_ Date \_\_\_\_\_

*For first-time applicant, after you complete this application form, attach your essay, and, if available, a copy of your letter of college acceptance. Send your completed application to College Foundation, Inc., Attn: Grants and Scholarships Manager, P.O. Box 41966, Raleigh, North Carolina 27629-1966 for the scholarship selection process.*

*For renewal applicant, be sure you have completed Sections 1, 3, 4 and 6. A certified copy of your academic transcript from the college attended this past year must be attached.*

**PRIVACY:** College Foundation, Inc., (CFI), Robert A. Jones, and the American Syringomyelia Alliance Project, Inc., (ASAP) are committed to protecting the confidentiality of all nonpublic personal information collected from applicants of The Bobby Jones Open Scholarship. CFI, Robert A. Jones, and ASAP require that each party maintain the confidentiality of all nonpublic personal information and use reasonable safeguards to protect the information. Each party will not disclose nonpublic personal information to any third-party unless such third-party needs the information to carry out an intended purpose of The Bobby Jones Open Scholarship and has agreed in writing to protect and safeguard the information.