Charles L. Shor Scholarship Fund

PHYSICIAN DIAGNOSIS VERIFICATION FORM

This form must be filled out by your Physician..

Student Information

Student Name:

Date of Birth:

Physician Information

Physician Name:

Practice / Clinic:

Address:

Diagnosis Verification (To be completed by the treating physician)

The student has a physician-documented diagnosis of epilepsy.

YES ☐ NO ☐

The student has experienced active epileptic seizures within the previous 12 months.

YES ☐ NO ☐

The student is currently under your care for epilepsy management.

YES ☐ NO ☐

The student is currently being treated with prescribed epilepsy medication(s).

YES ☐ NO ☐

Optional Notes / Relevant Information:

Physician Certification

I certify that the above information is accurate to the best of my knowledge and reflects the student's current medical status.

Physician Signature:

Date:

Physician Phone:

Physician Email:

Physician Fax: