Rick Hansen Foundation

Proof of Disability Form

The Rick & Amanda Hansen Scholarship for Youth with Disabilities

This form is to be completed by a physician or psychiatrist licensed in Canada who is most familiar with your medical condition.

1. Applicant Details

Legal First Name	
Legal Last Name	
Birth Date	

2. Physican Details

Physician Full Name	
Specialty	
Medical License Number	
Province/Territory of Registration	
Medical Office Mailing Address	
Primary Phone Number	
Email Address (optional)	

3. Disability Information

The Applicant has a permanent disability defined as a functional limitation, whether permanent or episodic, which affects the Applicant's ability to participate fully in post-secondary education.	Yes ☐ No ☐
Applicant's Diagnosis	
Description of disability, including how the disability limits the Applicant's ability to participate fully in post-secondary education.	

4. Physician's Consent

By signing this form, I understand that I am providing information which the Rick Hansen Foundation will use to determine the Applicant's eligibility for the Rick & Amanda Hansen Scholarship for Youth with Disabilities. I accordingly confirm that all of the information I have provided is complete, true and accurate to the best of my knowledge.

Physican Signature:

Date (mm/dd/yyyy):

Physican office stamp