**VERIFICATION OF CHRONIC ILLNESS FORM**

**Anne Nymark Young Adult Continuing Education Grant**

**Submission Deadline is May 1st**

*Verification from medical provider is needed for patient to apply for the grant and MUST be completed and signed by* ***medical provider****.*

The purpose of the grant program is to encourage young adults (up to 35 years old), who grew up with pediatric chronic illnesses, to further their education.

**Grants are awarded to young adult students who are Florida residents and:**

1. have an ongoing chronic illness/disease with initial diagnosis under 18 years old (*Verification of Chronic Illness* form must be completed by doctor for eligibility).

*As a requirement for this grant, “Chronic illness/diseases are defined as medical conditions that require ongoing medical attention or limit activities of daily living or both AND diagnosis occurred in childhood and has continued into adulthood”.*

1. are committed to, enrolled in or accepted for admission to full-time or part-time academic program, community college, university, career industry program, technical education**,** trade school, certification program, training academy, or technician program.
2. have completed grant application and forms.

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Dx: \_\_\_\_\_\_\_\_

Other Diagnoses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this applicant receiving ongoing medical care/treatment? \_\_\_\_ Yes \_\_\_\_ No

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does applicant have limitations or struggles with daily living? \_\_\_\_Yes \_\_\_\_ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature of Physician Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Facility Email Phone Number

*Please return to applicant to submit with grant application paperwork or mail to:*

Purple Playas Foundation

Attention: Grant Committee

16608 Lake Heather Dr.

Tampa, Fl. 33618