MTS SICKLE CELL FOUNDATION, INC.

WARRIOR ON THE RISE SCHOLARSHIP
DIAGNOSIS VERIFICATION FORM
TO BE COMPLETED BY TREATING PHYSICIAN

The information requested below is necessary to complete the patient or his or her family member's application for the MTS Sickle Cell Foundation's Warrior on the Rise Scholarship Application

To apply for the MTS Sickle Cell Foundation's Warrior on the Rise Scholarship, student must have a Sickle Cell Disease diagnosis or is the sibling or child of a Sickle Cell Disease patient and lives in the same household the patient on this form. Patients who have been cured of Sickle Cell Disease within the last five (5) years and their siblings or children are also eligible to apply.

Diagnosis is considered active and eligible to apply if the patient is currently and actively being treated and managed for Sickle Cell Disease. **Scenarios demonstrating active Sickle Cell Disease status include:**

- Active treatment by a licensed hematologist specializing in Sickle Cell Disease
- Current Sickle Cell Disease drug therapy such as Hydroxyurea, Oxbryta, ADAKVEO, etc.
- Current pathology revealing Sickle Cell Disease
- A newly diagnosed patient awaiting treatment
- Affirmation of current disease management
- The completion of Bone Marrow Transplant or Gene Therapy and the patient is still receiving ongoing treatment.

Diagnosis is considered historical and not eligible to apply if:

- Sickle Cell Disease was successfully cured via Bone Marrow Transplant or Gene Therapy over five (5) years ago.

Diagnosis and Treatment Information

Patient's Full Name:____

Type of Sickle Cell Diagnosis:____

Has the patient been diagnosed with and/or been cured for Sickle Cell Disease within the past five (5) years? YES ☐ NO ☐

Date of Diagnosis:____

Began active treatment or will begin active treatment on:______________________

Cured of Sickle Cell Disease on:____

MTS SICKLE CELL FOUNDATION, INC.

WARRIOR ON THE RISE SCHOLARSHIP
DIAGNOSIS VERIFICATION FORM
TO BE COMPLETED BY TREATING PHYSICIAN

Treating Physician Information

Physician's Full Name:____

Facility/Practice Name:____

DEA/NPI Number:____

Street Address:____

City:_______________________________________ State:______________ Zip Code:_____________________

Telephone:_______________________________Ext:________________ Fax:______________________________

Office Contact Name:____

Physician's Office Contact Email:____

Physician Attestation

I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of MTS Sickle Cell Foundation's Warrior on the Rise Scholarship, its representatives, and/or agents assigned to assess the patient or his or her sibling's eligibility for participation in the Program. I understand that application to the MTS Sickle Cell Foundation's Warrior on the Rise Scholarship program does not guarantee financial assistance.

Physician's Signature:____ Date:_________________________