

<i>For office use only</i>	
Membership list	
Amount approved	
Date approved	



To support, empower, and connect all those impacted by Spina Bifida in Indiana

CAMP SCHOLARSHIP APPLICATION

20_____

Camp Application Guidelines: THIS APPLICATION MUST BE SUBMITTED PRIOR TO ATTENDING

- Applicant must have Spina Bifida. *When the applicant is making his or her first application to SBIND for funds, a letter from a physician confirming that the patient has Spina Bifida is required.*
- Applicant must provide all requested information unless otherwise noted.
- Eligible camps include: A. Camps specifically designed for people with disabilities: B. Special events upon board approval.
- Disbursements will go directly to the camp listed.
- Applicant will supply his/her photograph(s) at camp and short description or drawing of what attending camp means to them. These will be used in SBIND communications.

Return all applications to: Scan and attach to an email to sbindoffice@sbind.org (preferred)
Or send to SBIND PO Box 40558 Indianapolis, IN 46240

APPLICANT INFORMATION		
Name of Individual with Spina Bifida:		
Name of Parent or Guardian (if a minor):		
Current Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email Address:		Date of Birth:
Camp Name:	Camp Dates:	Camp website:
(Please complete if other than Camp Riley) Camp Contact Name:		Camp Contact email and/or phone:
Additional Information:		
REQUESTED AMOUNT (REQUEST CANNOT EXCEED \$500 PER CALENDAR YEAR) -		
By signing below, I certify that all the information provided is true and correct. If any information is intentionally false, I agree to reimburse SBIND all costs, legal and otherwise, to recover the disbursed funds.		
I understand that the information supplied on this form will be added to the SBIND membership & mailing database at no cost to me.		
I give permission for camp attendee photograph(s) & note/drawing to be used in SBIND communications.		
Signature of applicant (or parent or guardian if a applicant is a minor):		Date: