VISUAL AID VOLUNTEERS OF FLORIDA, INC.

SCHOLARSHIP APPLICATION

The Visual Aid Volunteers of Florida, Inc. (VAVF) awards educational scholarships to qualified high school seniors who are **legally blind**, **Florida residents** and **continuing their education.** Scholarship awards will be sent directly to the school the student will be attending. All responses will be confidential. Please answer all of the following questions fully. Deadline for receipt of all applications is **March 30, 2017.** **Applications received after this date will not be considered.** Send completed applications to:

Mariann Witengier
VAVF Scholarship Committee
2900 Harriet Drive
Orlando, FL 32812

You must be legally blind to qualify for this scholarship. Your eye doctor must fill out the enclosed form. It must be included with your application.

1. Name: ____
   Last First Middle

2. Social Security Number: ________________________________
   NOTE: Social Security Number is required for scholarship to be awarded.

3. Address: Street ____

   ____
   City State Zip

4. Telephone number: ______________________________________

5. E-mail address:____

6. Date of birth: ____

7. High School attended: ___________________________________

   Address: ____

   Date of graduation: ______________________________________

   Grade point average: _____________________________________

8. What College or University do you plan to attend?

Name: ____

Address:____

Date of entrance: ____

9. Please state your career goals.

10. List all extracurricular activities/community service in which you have been actively involved, both past and present.

11. Attach **3** letters of recommendation from your school counselor, physician, current or former teachers, club directors, or community leaders attesting to your scholastic aptitudes, character, and reliability. All letters will remain in strictest confidence.

12. Attach a short paper (1 print page/2 braille pages) in which you tell us about yourself and explain how this scholarship will make a difference to you. Include information about the extent of your visual impairment.

13. Attach a copy of your **high school** transcript.

Signature: ____

Date: ____

Checklist:

__ Completed application
__ Completed form from your eye doctor
__ 3 letters of recommendation
__ Essay about yourself and importance of scholarship to you
__ High school transcript
__ Sign and date the application
__ Meet the March 30, 2017 deadline

VAVF SCHOLARSHIP
EYE DOCTOR REPORT

NAME: ____Social Security No: _______________________

DATE OF ONSET OF PATHOLOGY: R.E. __________L.E. ___________EXAM DATE: __________

DIAGNOSIS:

ETIOLOGY:

DESCRIBE EXTERNAL AND INTERNAL APPEARANCE OF EYES:

R.E. ____

L.E. ____

VISUAL ACUITY (With Best Correction):

R.E. Distance ____________Near ________________

L.E. Distance ____________Near ________________

Are new glasses recommended? Yes No Was a prescription given to patient? Yes No

VISUAL FIELDS:

Is there any abnormality or limitation in field of vision? Yes No

If yes, what is the widest diameter in degrees in remaining field? R.E. ___________L.E. __________

PROGNOSIS: R.E. ____________________________L.E. ___________________________________

DEFINITION OF DEGREE OF BLINDNESS:

Central visual acuity 20/200 or less in the better eye with correction glasses, or a disqualifying field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees and which is sufficient to incapacitate the individual for self support.

1. In your opinion does this patient meet this degree of blindness? Yes No
2. In your opinion can this patient be improved by medical treatments? Yes No
3. In your opinion can this patient be improved by surgical procedures? Yes No

Physician's Signature __________________________________M.D. Phone No. ___________________