AbbVie IBD Scholarship Program
Brought to you by Crohn's and Colitis Canada

ABBVIE IBD SCHOLARSHIP PROOF OF DIAGNOSIS FORM

This section to be completed by Scholarship Applicant

Applicant Name: _____

Health Care Provider Name: _____

Hospital or Clinic Name: _____

Street Address: _____

City: _____

Prov: _____ Postal Code: _____

Office telephone: _____

Health Care Provider E-mail: _____

This section to be completed by Health Care Provider

Please provide a brief summary of the applicant's medical history as it relates to their diagnosis of inflammatory bowel disease.

I certify that this applicant is under my medical care and has been diagnosed with:

- Crohn's disease
- Ulcerative colitis
- Or another form of inflammatory bowel disease

Signature: _____ Date: ____/_____/_____

Credentials: _____