Request number:

LVHN CFM SCHOLARSHIP REQUEST FORM

Name_____
Date_____
Cycle Requested (Season + Year) _____

Are you a: **LVHN employee?** Yes/No **Medical Student or Resident?** Yes/No

Your Goals for Participation:

1. _____
   _____
2. _____
   _____
3. _____
   _____

How would you rate your **capacity to participate in the program** including attending all 9 sessions, and engaging in home practice regularly?

Low_____Medium_____High

The scholarship is for $250 of the $375 registration fee. **Will you be able to pay the remaining registration fee of $125?** Yes/No

Please tell us what you can about your **financial situation** that makes the registration fee unmanageable for you:

Any other comments you would like to make?