

2009 FCCLV SCHOLARSHIP APPLICATION

(Please print out and complete the following application.)

I. PERSONAL DATA:

Name: _____

Address: _____

City/State/Zip: _____

Summer address: (if different from above)

Address: _____

City/State/Zip: _____

Daytime Phone: (_____) _____

Evening Phone: (_____) _____

Male _____ Female _____ Date of Birth: _____

II. VISUAL STATUS:

Check all the methods you use for reading:

() Braille () Recordings () Large print ()
Regular print () Live reader

III. EDUCATIONAL BACKGROUND:

A) Name and address of school in which you are currently enrolled or last attended:

Name: _____

Address: _____

City/State/Zip: _____

Grade point average (based on 4.0 scale): _____

Major: _____

No. of hours: _____

Degree/Certificate sought: _____

Date degree expected: _____

B) School you plan to attend (if different from above)

Name: _____

Address: _____

City/State/Zip: _____

Major: _____

Number of hours: _____

Degree/Certificate sought: _____

Date degree expected: _____

C) List any secondary or post-secondary schools which you have attended:

Name of school: _____

City/State/Zip: _____

Grade point average (based on 4.0 scale): _____

Dates attended: From: _____ To: _____

Name of school: _____

City/State/Zip: _____

Grade point average (based on 4.0 scale): _____

Dates attended: From: _____ To: _____

IV. WORK EXPERIENCE:

Please attach a list of any full-time or part-time work experience you may have. Indicate whether this is summer employment or during the school year.

V. EXTRACURRICULAR ACTIVITIES:

Please attach a list of any major outside activities (school, church, community, sports, organizations, recreation, etc.). Indicate extent to which you have acted in a leadership role.

VI. CERTIFICATION OF VISUAL STATUS

To be completed by a physician or agency executive serving people with low or no vision.

This is to certify that the person named on this scholarship application is known to me and is legally blind.

Cause of visual impairment: _____

Visual Acuity: Right eye: _____ Left eye: _____

Name: _____

Title: _____

Address: _____

City/State/Zip: _____

Telephone number: _____

Signature: _____

Date: _____

Please forward application (including sealed official transcript) postmarked NO later than March 31, 2009 to:

Florida Council of Citizens with Low Vision
Barbara H. Grill
2030 Preymore Street
Osprey, FL 34229

If you have any questions, contact Barbara at (941) 966-7056 or grillbh@comcast.net.