Post-Secondary Education Scholarship Application

Up to $500 Post-secondary Scholarships are limited and will be awarded by discretion of the SBSTL Board.

You will be notified of your acceptance.

Date: _____

Name of Individual with Spina Bifida: _____

Birth Date: _____

Name of Parents or Guardian (if a minor):_____

Address: _____

Phone: _____Cell:_____

E-mail Address: _____

Name of School and Program/ Major: _____

Address of School: _____

Name and Phone Number of School Administrator: _____

Cost per year: _____ Amount Requested: _____

Date attending: _____ Check Payable to: _____

BY SIGINING BELOW I CERTIFY THAT ALL THE INFORMATION PROVIDED IS TRUE AND CORRECT. I CERTIFY THAT THE ITEMS LISTED ARE FOR THE BENEFIT OF THE APPLICANT. IF ANY INFORMATION IS INTENTIONALLY FALSE, I AGREE TO REIMBURSE SBSTL ALL COSTS LEGAL AND OTHERWISE, TO RECOVER THE DISBURSED FUNDS.

Signature _____

Please provide a copy of the invoice for the expenses being reimbursed above.

Please send the application for consideration to:

Spina Bifida of Greater St. Louis (SBSTL)
9201 Watson Road, Suite 125
Crestwood, MO 63126

For more Information, call 800-784-0983