



# **SCHOLARSHIP TRUST FOR THE HEARING IMPAIRED**

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3755 LINDELL BOULEVARD  
ST. LOUIS, MO 63108-3476  
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sponsored by The *Travelers Protective Association*

## **GENERAL GUIDELINES**

**OF**

## **THE TPA SCHOLARSHIP TRUST FOR THE HEARING IMPAIRED**

The objects and purposes of this Trust in general are the giving of financial aid or assistance to residents of the United States or its' possessions who suffer deafness or hearing impairment; who will benefit from medical, mechanical, specialized treatment or specialized education and who are unable to provide the funds therefore themselves.

The funds necessary to effectuate the above shall be obtained from tax deductible gifts, bequests and devises obtained from individuals, firms, trusts, corporations, other entities and from accretions of investments to the Trust funds.

Applications for charitable assistance must be submitted on the approved Trust application form by adults or if a minor, by the person having legal custody.

Approved Trust applications shall be submitted to the Board of Trustees or in the interim between annual meetings to the Trust Executive Committee.

The selection of recipients of Trust scholarships and the amount thereof shall be within the sole discretion of the Board of Trustees or the Trust Executive Committee.

The selection and amount of aid shall be granted only upon concurrence of a majority of the full Board of Trustees or full Trust Executive Committee.

In all cases, the Declaration of Trust and Bylaws thereof shall be followed and complied with in full.



12. School information:  
School applicant attending: \_\_\_\_\_  
Grade: \_\_\_\_\_ Public: \_\_\_\_\_ Private: \_\_\_\_\_  
Approximate tuition costs annually: \_\_\_\_\_  
Financial assistance from other sources: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. What insurance does applicant have: (Include only major medical, medical pay and Blue Cross-Blue Shield)

(a)	_____	_____
	Name of Company	Type of Coverage
(b)	_____	_____
	Name of Company	Type of Coverage
(c)	_____	_____
	Name of Company	Type of Coverage
(d)	_____	_____
	Name of Company	Type of Coverage

14. Describe hearing defect in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Date of onset of defect: \_\_\_\_\_

16. Prior medical treatment (give names and address of doctors):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Intended use of grant and anticipated costs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant-Parent/Guardian \_\_\_\_\_

**FULL RELEASE**

I/We, \_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ an individual/parents of a minor

hereby grant permission to The Scholarship Trust for the Hearing Impaired, 3755 Lindell Boulevard, St. Louis, Missouri 63108-3476, its Trustees and employees, to take photographs and/or video tapes of said individual/minor child. I/We hereby authorize the exhibition, reproducing, publishing, televising and use of these photographs and/or video tapes for educational, information, and advertising purposes, including, but not by way of limitation, publication in the Travelers Magazine and use of said individual/minor's name and address in conjunction therewith.

In our/my own behalf, and in behalf of \_\_\_\_\_,

I/We hereby relinquish all right, title and/or interest that \_\_\_\_\_  
I/We may have to such video tapes, finished pictures, negatives, reproductions and copies of the original prints and negatives, and further grant unto The T.P.A. Scholarship Trust for the Hearing Impaired the right to exhibit, assign and transfer in whole or in part, said video tapes, negatives, original prints, and copies, or facsimiles thereof.

This instrument shall be binding upon the undersigned, and the undersigned's heirs, executors, administrators, successors and assigns.

Witness my/our hand at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Individual/Parent

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

**NOTE**

Please include Photo of Applicant with this form.

# MEDICAL AUTHORIZATION

Date \_\_\_\_\_

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to furnish T.P.A. Scholarship Trust for the Hearing Impaired, or its representative, any and all information you may have concerning \_\_\_\_\_ with respect to any hearing defect, illness or injury, medical history, consultation, prescription or treatment, including x-ray plates and copies of all hospital or medical records.

Witness to Signature: \_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_  
Address: \_\_\_\_\_

A photostatic copy of this authorization shall be considered as effective and valid as the original.

## T.P.A. Scholarship Trust for the Hearing Impaired

3755 Lindell Boulevard, St. Louis, Missouri 63108-3476

### MEDICAL CERTIFICATION

1. Name of Patient: \_\_\_\_\_
  2. Diagnosis of Hearing Defect: \_\_\_\_\_
  - 2a. Degree of Loss: \_\_\_\_\_ Right Db. \_\_\_\_\_ Left Db.
  3. Date of Diagnosis: \_\_\_\_\_
  4. Medical Recommendation for Future Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  5. Estimated Cost of Recommended Treatment: \$ \_\_\_\_\_  
Mechanical or Electronic Devices: \$ \_\_\_\_\_
  6. Prognosis for Cure or Improvement with Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  7. To the best of your knowledge, is patient able to supply costs of recommended future treatment?  
Yes: \_\_\_\_\_ No: \_\_\_\_\_
  8. If medical treatment and/or mechanical or electronic aids will not benefit patient, is specialized education or training recommended? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, describe type and place of education or training: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  9. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Date: \_\_\_\_\_

Signature of Physician/Audiologist

Street Address

City

State

Zip