UCB Hidradenitis Suppurativa Scholarship™

PROVIDED BY ucb Inspired by **patients.** Driven by **science.**

DEADLINE: September 1, 2026

SECTION 4: TO BE COMPLETED BY HEALTHCARE TEAM MEMBER

(Full medical history is not required but is accepted.)

A. Instructions for Applicant: The healthcare team includes physicians, nurse practitioners, physician assistants, nurses, social workers, or any certified practitioner who is directly involved in the medical care of the patient living with hidradenitis suppurativa. If the applicant is a family member of someone living with hidradenitis suppurativa, this section should be completed by the healthcare team member who cares for the patient living with hidradenitis suppurativa. If you are a family member applying for a scholarship, you may obtain a recommendation letter from an alternate source but the Medical History form below is still required.

B. Instructions for Healthcare Team Member: The individual listed below is applying for the UCB Hidradenitis Suppurativa Scholarship™. The purpose of this scholarship program is to provide financial support for the education of people impacted by hidradenitis suppurativa, including patients and family members. UCB, Inc. seeks to recognize the personal achievements of those people impacted by hidradenitis suppurativa. Eleven one-time scholarships will be awarded to people living with hidradenitis suppurativa, and to family members of people living with hidradenitis suppurativa, for use toward tuition at a United States–based center for higher learning (trade school, associate's, bachelor's, master's degree, etc.).

APPLICANT INFORMATION (Please Print or Type):

Name: ____

Permanent Home Address: ____City:______________

State: ________________ ZIP: _________________ Email: ________________________________

Primary Telephone: ________________________________ Alternate Telephone: ____________________________

Date of Birth (mm/dd/yyyy): ____________________ Sex (please check one): ❑ Male ❑ Female

Applicant Status (please check one): ❑ Person with hidradenitis suppurativa ❑ Family member

If you are a family member, please describe your relationship to the person with hidradenitis suppurativa:

____

PATIENT INFORMATION:

To be completed by the healthcare team member caring for the person with hidradenitis suppurativa. You may write "same as above" if the patient is also the applicant.

Name: ____

Home Address: ____

City: ____ State: ________ ZIP: ____________________

Date of Birth (mm/dd/yyyy): ________________ Sex (please check one): ❑ Male ❑ Female

PATIENT'S MEDICAL HISTORY:

1. I certify that this patient has been diagnosed with hidradenitis suppurativa (check one): ❑ Yes ❑ No
2. Please provide the date on which this diagnosis was made (mm/dd/yyyy): ______________________________
3. Indicate the patient's type of hidradenitis suppurativa: ______________________________________
4. Current therapies for hidradenitis suppurativa: ____

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5. Please share any additional comments regarding the patient's medical history: ________________________

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Contact us at ucbhsscholarship@summitmedcomm.com or 1-844-652-0779 for additional information or answers to questions.

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(Section 4 cont'd)

I certify that this patient is under my medical care for hidradenitis suppurativa.

Your Name (please print or type): ______________________________ Phone: ______________________________

Office Address: ____

City: ______________________________ State: _______________ ZIP: ______________________________

Email: ____

Signature: ______________________________ Credentials: ______________________________

Nature of the Relationship of Patient to the Applicant (self/brother/sister/parent, etc.): ______________________________

REQUIRED RECOMMENDATION FROM HEALTHCARE TEAM MEMBER:

The healthcare team includes physicians, nurse practitioners, physician assistants, nurses, social workers, or any certified practitioner who is directly involved in the medical care of the patient living with hidradenitis suppurativa (HS). If the applicant is a family member of someone living with HS, this section should be completed by the healthcare team member who cares for the patient living with HS. The healthcare team member must also provide the patient's medical history when submitting the recommendation letter. If the healthcare provider chooses not to provide a letter of recommendation, they still must complete the patient's medical history form AND notify the applicant that they will not be providing a recommendation letter, as the applicant must then obtain a letter of recommendation from an alternate source (school official, community member) to be considered for the scholarship.

The one-page recommendation letter can include:

- The severity of the *patient's* type of hidradenitis suppurativa
- The nature of your relationship with the *applicant*
- The *applicant's* unique qualities
- The impact hidradenitis suppurativa has had on the *applicant's* daily activities
- How the *applicant* has positively dealt with HS as part of their life, either as a person living with HS or as a family member to a person living with HS

Please send application and all letters of recommendation postmarked by September 1, 2026 to:
UCB Hidradenitis Suppurativa Scholarship™ c/o Summit Medical Communications
1441 E. Broad Street, Suite 340, Fuquay-Varina, NC 27526

Contact us at ucbhsscholarship@summitmedcomm.com or 1-844-652-0779 for additional information or answers to questions.

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