



DEADLINE: January 31, 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 myasthenia gravis. If the applicant is a family member of someone living with myasthenia gravis, this section should be completed by the healthcare team member who cares for the patient living with myasthenia gravis. 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 Myasthenia Gravis Scholarship™. The purpose of this scholarship program is to provide financial support for the education of people impacted by myasthenia gravis, including patients and family members. UCB, Inc. seeks to recognize the personal achievements of those people impacted by myasthenia gravis. Fifteen one-time scholarships will be awarded to people living with myasthenia gravis, and to family members of people living with myasthenia gravis, for use toward tuition at a United States-based center for higher learning (trade school, associate's, bachelor's, or master's degree, etc.).

APPLICANT INFORMA	TION (Please Print or Type)			
First Name:	Last Name:			
Permanent Home Address (No P	O Boxes):		City:	
State:	ZIP: Email			
Primary Phone:	Alternate Phone:			
Date of Birth (mm/dd/yyyy):	Sex (select one):	☐ Male ☐	l Female	
Application Status (please check	one): \Box Person with myasthenia gravis \Box F	amily Member		
If you are a family member, pleas	se describe your relationship to the person with myast	henia gravis:		
To be completed by the healthcare to	eam member caring for the person with myasthenia gra	•		
To be completed by the healthcare to Name:	eam member caring for the person with myasthenia gra			
To be completed by the healthcare to Name:Home Address:	eam member caring for the person with myasthenia gra	, 		
Name: Home Address: City:	eam member caring for the person with myasthenia gra	ZIP:		
To be completed by the healthcare to Name: Home Address: City: Date of Birth (mm/dd/yyyy):	eam member caring for the person with myasthenia gra	ZIP:		
To be completed by the healthcare to Name: Home Address: City: Date of Birth (mm/dd/yyyy): PATIENT'S MEDICAL HIS	eam member caring for the person with myasthenia gra	ZIP: Male	☐ Female	
To be completed by the healthcare to Name: Home Address: City: Date of Birth (mm/dd/yyyy): PATIENT'S MEDICAL HIS I. I certify that this patient has been	eam member caring for the person with myasthenia gra State: Sex (Please Check One): STORY:	ZIP: Male	☐ Female	
To be completed by the healthcare to Name: Home Address: City: Date of Birth (mm/dd/yyyy): PATIENT'S MEDICAL HIS 1. I certify that this patient has been 2. Please provide the date on which	eam member caring for the person with myasthenia gra State: Sex (Please Check One): STORY: I diagnosed with myasthenia gravis (check one):	ZIP: Male	☐ Female	
To be completed by the healthcare to Name: Home Address: City: Date of Birth (mm/dd/yyyy): PATIENT'S MEDICAL HIS 1. I certify that this patient has been 2. Please provide the date on which 3. Indicate the patient's type of mya	eam member caring for the person with myasthenia grammember caring for the person with	ZIP:	☐ Female	

Contact us at ucbmgscholarship@summitmedcomm.com or 1-833-821-0255 for additional information or answers to questions.





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(Section 4 cont'd)			
I certify that this patient is under my me	edical care for myasthenia gravis	š.	
Your Name (Please print or type):		Phone:	
Office Address:			
		ZIP:	
Email:			
Signature:			
Nature of the Relationship of the Patier	nt to the Applicant (self, brother, s	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 myasthenia gravis (MG). If the applicant is a family member of, or caregiver to, someone living with MG, this section should be completed by the healthcare team member who cares for the patient living with MG. 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 MG
- The nature of your relationship with the applicant
- The applicant's unique qualities
- The impact MG has had on the applicant's daily activities
- How the applicant has positively dealt with MG as part of their life, either as a person living with MG or as a family member to a person living with MG

Please send application and all letters of recommendation postmarked by January 31, 2026 to:

UCB Myasthenia Gravis Scholarship™ c/o Summit Medical Communications 1441 E. Broad Street, Suite 340, Fuguay-Varina, NC 27526

Contact us at ucbmgscholarship@summitmedcomm.com or 1-833-821-0255 for additional information or answers to questions.

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