UCB MYASTHENIA GRAVIS SCHOLARSHIP™

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DEADLINE: February 15, 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 INFORMATION (Please Print or Type)

First Name: _____ Last Name: _____

Permanent Home Address (No PO Boxes): _____ City: _____

State: _____ ZIP: _____ Email: _____

Primary Phone: _____ Alternate Phone: _____

Date of Birth (mm/dd/yyyy): _____ Sex (select one): ❑ Male ❑ Female

Application Status (please check one): ❑ Person with myasthenia gravis ❑ Family Member

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

_____

PATIENT INFORMATION:

To be completed by the healthcare team member caring for the person with myasthenia gravis. 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 myasthenia gravis (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 myasthenia gravis: _____
4. Current therapies for myasthenia gravis: _____

_____

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

_____

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 medical care for myasthenia gravis.

Your Name (Please print or type): _____ Phone: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Signature: _____ Credentials: _____

Nature of the Relationship of the 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 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 February 15, 2026 to:
UCB Myasthenia Gravis Scholarship™ c/o Summit Medical Communications
1441 E. Broad Street, Suite 340, Fuquay-Varina, NC 27526

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