Financial Assistance and Hemophilia Provider Form

Applicant Information

Last:	First:	Middle Initial:	Title (MD, PhD, etc.)
Job Title			Specialty/Subspecialty
Address:			
City:	State:	ZIP:	Phone:

Organization

Type of Business		
Organization/Company Name/School/Institution		
Email Address		
Phone Number		
Address:		
City:	State:	ZIP:
Website:		

Applicant Funding & Proficiency Information

Please note: starting 1/1/2023 we will be charging a $300 non-refundable administrative registration fee.

1. What is your motivation to take the MSKUS training course? How will MSKUS be applied in your practice?
2. Describe any financial barriers and needs required to attend the MSKUS training course?

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Applicant Funding & Proficiency Information continued

3. Are you receiving any additional funding/support from your employer or other organization?

3.1. How much total funding are you requesting for MSKUS Training (USD)? Check courses and costs below:

Courses and costs

☐ *Musculoskeletal Ultrasound Training for Arthritic conditions: Ankle, Knee, and Elbow - Basics and Techniques Online program:* $1200

☐ *Musculoskeletal Ultrasound Training in Hemophilia Online Program*: $1200

☐ *Musculoskeletal Ultrasound Training for Hemophilia and Other Arthritic Conditions Live Course:* $950 per day, 3 days maximum

☐ Other _____

_____

Total Amount Requested _____

4. If applicable, are you currently using ultrasound for joint evaluations in patients with hemophilia? ☐ Yes ☐ No

If your answer is yes, please specify how many times per month.

5. If applicable, please provide your hemophilia treatment center director's name and contact information below. At the end of this document, please have the same director sign below.

Name & Credentials: _____

Phone Email

6. If you are a current student or trainee, please describe what you are currently studying, your background, and reasons for your interest in MSKUS. Please attach verification of enrollment and letter of support from your institution/university.

7. What have we not asked you and your organization about that you feel is important?

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Application Received:	
Total Amount Requested:	
Approval	
☐ Partial Waiver	☐ Full Waiver $
Comments:	
Authorized Signature:	
Print name	Signature

I hereby certify that the information contained herein is complete and accurate. This information has been furnished with the understanding that it is to be used to determine the amount and conditions of the credit to be extended. Furthermore, I hereby authorize the financial institutions listed in this credit application to release necessary information to the company for which credit is being applied for in order to verify the information contained herein.

Signature of Applicant	Date
Signature of HTC Director (if applicable)	Date

Please sign, scan, and email completed application and supporting documentation (if applicable) to:

Marlene Zepeda at ucsdmskus@health.ucsd.edu

health.ucsd.edu/specialties/hematology/hemophilia

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