CRMC
CUYUNA REGIONAL MEDICAL CENTER
Dedicated to You. Every Day.

Scholarship Application for Camp Needlepoint

Please Print:

Name:_____
(Last) *(First)* *(Middle initial)*

Parent's Name:_____
(Last) *(First)* *(Middle initial)*

Applicant Birthdate:_____/_____/_____
(Month) *(Day)* *(Year)*

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Other Phone:_____

Primary Clinic: _____ Phone Number: _____

Primary Physician:_____

Date of Diagnosis with Type 1 Diabetes:_____

Have you attended Camp Needlepoint in the past? ☐ Yes ☐ No If yes, dates:_____

Signature:_____ Date:_____

Please mail completed application to:

Cuyuna Regional Medical Center
Attn: Diabetes Education
320 East Main Street
Crosby, MN 56441

For Office Use Only:

Reviewed By:_____ Date:_____

Eligible: ❒ YES ❒ NO