



**British Columbia Schizophrenia Society
Victoria Branch**

MEMORIAL FUND APPLICATION

Applicants must reside on Southern Vancouver Island

Name: _____

Address: _____ Postal Code: _____

Telephone: _____ Psychiatrist's Name: _____

School: _____ Course name & number: _____

Email: _____

(Internet courses and courses outside B.C. will not be accepted for funding.)

Brief Description of Request: _____

Funds Requested: \$ _____

Have you applied for funds from the Memorial Fund before? Yes: _____ No: _____

What other sources of funding have you approached? _____

Sources of income: _____

Referred by: _____ **Title:** _____

Please enclose a letter of referral with this application. Applications will not be processed without a referral from a medical or mental health professional.

Applications for funding may be considered for the following circumstances only:

1. Compassionate needs for family members.
2. Continuing education or compassionate needs for individuals suffering from schizophrenia or other serious mental illness.

Consent: I understand the eligibility as outlined above and am aware that my application may be refused at the discretion of the Memorial Fund Committee.

Date: _____ Signature: _____

NOTE: Please allow one to two weeks following APPROVAL of this application for cheque processing