FRIENDS OF
The Congressional Glaucoma Caucus
FOUNDATION

Application for the Student Sight Savers Program

1. Name of Applicant: Date:
   Primary contact information:
   E-mail :
   Telephone number:
   Fax number:
   Other Number(s):
   Address:
2. Applicant Institution:
3. Position (pls. check one): Student Resident Staff
4. Briefly describe previous experience with Medical outreach programs:
5. Why are you interested in the SSS Program:
6. Name of Dean or Dean's Representative (attach letter of support required):
7. Name of Faculty Member in the Department of Ophthalmology that would directly oversee the SSS Program is necessary (pls. attach letter of support):
   Telephone number: Fax number:
   Email: Glaucoma Specialist (pls. check one) yes no
8. Please indicate the number of screenings you can do in the next 12 months. The current average is 8-10 screenings per year with about 40 patients screened per screening:
9. How would you provide eye care for uninsured patients? Please comment.
10. Please attach your responses for the following questions:
    a. Please describe the reasons why a glaucoma screening program will be important in your community?
    b. Describe the mechanism by which first and second year students will be recruited to join the program. What type of training and supervision are available? If necessary, we can assist with training.
    c. Attach a one-page budget for the program. This budget includes an initial capital of $19,100 ($10,100 of which is allocated for equipment and $9,000 for two-year period of screening expenses).
11. Check(s) are to be made payable to:

    Send Check To:

    Address for shipping equipment and all other project /screening materials should be send to:

Please send the completed form along with attachments to:
Friends of The Congressional Glaucoma Caucus Foundation
1983 Marcus Ave. Suite 111
Lake Success, NY 11042
Toll-free: 877-611-4232 Phone# 516-327-2236 Fax# 516-327-0260