The Reginald Anderson Memorial Scholarship

"Reginald Anderson was full of life, love, and laughter. His beautiful and contagious smile would light up a room. Reginald passed away in 2014 after a courageous battle with glioblastoma, but his legacy lives on in the Reginald Anderson Memorial Scholarship.

Education was very important to Reggie. He graduated from South Windsor High School where he played football as a defensive lineman. He advanced to Springfield College and graduated with a B.S. in Social Services. He was employed by the State of Connecticut as an adult probation officer, enjoyed his job, and took pride in his role. He treasured traveling and learning new things. Reggie also loved shopping and had quite the hat collection. His kind, gentle soul lives on in the memories he has left his loved ones with." *~ Gina Lowther*

The Connecticut Brain Tumor Alliance, Inc. is pleased to offer the Reginald Anderson Memorial Scholarship, founded in 2015 by Gina Lowther with generous contributions from family, friends, and community members, to honor the life and legacy of Reginald Anderson.

We are now accepting applications for the 2025 Reginald Anderson Memorial Scholarship program. Applications must be postmarked by **May 16, 2025**, and scholarship recipient(s) will be notified by **May 30, 2025.**

Connecticut Brain Tumor Alliance Survivor Scholarship Program

The Connecticut Brain Tumor Alliance, Inc. was established to provide hope and support to brain tumor patients whose lives have been impacted by a brain tumor diagnosis. The Reginald Anderson Memorial Scholarship will be awarded based on the criteria listed below.

Eligibility: Applicants must meet all of the requirements listed below.

1. Must be a brain tumor survivor or recently diagnosed.
2. Must be currently enrolled in an accredited higher education institution or entering college in the semester following the award.
3. Must be a Connecticut resident and U.S. citizen.
4. Must have demonstrated financial need.

Checklist: All applications must include the following:

- Complete application forms
- Copy of college transcript or course registration/acceptance letter if you are an incoming freshman
- Resume including list of volunteerism or advocacy on behalf of brain tumor patients and their caregivers
- A typed statement about how your brain tumor journey has shaped, changed, and/or reinforced the principals by which you live your life. Please also comment on how you have used or plan to use your brain tumor experience to positively impact the lives of others.
- Signed Authorization statements
- A brief typed explanation of your current financial situation, how your brain tumor experience has increased your financial need, and how you will use the money if awarded.

Submission: Please mail completed application to:

The Reginald Anderson Memorial Scholarship
c/o The Connecticut Brain Tumor Alliance, Inc.
P.O. Box 370514
West Hartford, Connecticut 06137

Note: Please do not send applications via certified mail. You may email your application (as an alternative to mailing it) as a PDF file to Chris@ctbta.org. Please include all sections in one file.

Application Deadline: All applications must be postmarked/timestamped by May 16, 2025.
Award Notification Date: Scholarship recipient(s) will be notified by May 30, 2025.

2025 REGINALD ANDERSON SURVIVOR SCHOLARSHIP			
SECTION A: PERSONAL INFORMATION			
First Name:	Middle Initial:	Last Name:	
Address:			
City:	State:		Zip Code:
Home Phone:		Cell Phone:	
Email Address:			
Gender: _____Male _____Female	Date of Birth (mm/dd/yy):		Age:
SECTION B: CURRENT EDUCATION INFORMATION			
Current Grade Level as of Fall 2025:			
School Name:			
School Address:			
City:	State:		Zip Code:
Registrar's Office Phone Number (for verification only):			
Current GPA or High School GPA (for prospective college freshmen only):			
Major:		Minor:	
** Please attach a copy of your official transcript			
SECTION C: MEDICAL HISTORY			
Diagnosis:			
Date of Diagnosis:		Age at Diagnosis	
Are you currently undergoing treatment? _____Yes _____No			
When was your last treatment?			
Name and city of treatment center:			
Medical provider contact information and phone number (for verification only):			
** Please attach Physician Verification form			
SECTION D: FINANCIAL NEED			
Please list all total cost of education expenses and sources of financial assistance you will be receiving for the upcoming school year, including other scholarships.			
Total Estimate 2026-2026 Education Costs:			
Financial Aid Package from School, Loans & Other Sources:			

2025 REGINALD ANDERSON SURVIVOR SCHOLARSHIP	
SECTION E: AUTHORIZATIONS	
PLEASE READ EACH STATEMENT AND SIGN BELOW	
1) I CERTIFY THAT ALL STATEMENTS IN THIS APPLICATION ARE TRUE. I UNDERSTAND THAT THIS APPLICATION WILL BECOME THE PROPERTY OF THE CONNECTICUT BRAIN TUMOR ALLIANCE. I AGREE THAT MY ESSAY MAY BE REPRINTED IN PART OR IN FULL FOR THE PURPOSES OF EDUCATING, SUPPORTING, AND HELPING OTHERS AFFECTED BY A BRAIN TUMOR. 2) I AUTHORIZE THE REGISTRAR OF MY SCHOOL/COLLEGE/UNIVERSITY TO PROVIDE A REPRESENTATIVE OF THE CONNECTICUT BRAIN TUMOR ALLIANCE. WITH INFORMATION REGARDING MY ENROLLMENT STATUS AND VERIFICATION OF MY GPA AND/OR CREDITS EARNED. 3) I HEREBY AUTHORIZE _____ (MEDICAL PROVIDER LISTED ON THE APPLICATION) TO PROVIDE INFORMATION ABOUT MY MEDICAL CONDITION AND BRAIN TUMOR DIAGNOSIS TO A REPRESENTATIVE OF THE CONNECTICUT BRAIN TUMOR ALLIANCE IN ORDER TO SUPPORT MY SCHOLARSHIP APPLICATION.	
Signature:	Date:
Printed Name:	

PHYSICIAN VERIFICATION FORM	
Please have your physician complete this form and submit it with your application.	
Dear Doctor, The following applicant has applied for a Reginald Anderson Survivor Scholarship. Your cooperation in verifying his/her diagnosis is greatly appreciated. Please complete this form and return it to the applicant. The applicant is responsible for including this form in his/her application. Thank you for your assistance in this matter. If you have any questions, please feel free to contact the Connecticut Brain Tumor Alliance at scholarship@ctbta.org. Christopher Cusano CEO, Connecticut Brain Tumor Alliance, Inc.	
Applicant's Full Name:	
Diagnosis:	
Date of Diagnosis:	Age at Diagnosis:
Hospital/Neurology Practice	
Physician's Name:	
Address:	
Phone	
Physician Signature:	Date: