Spirit of Charity
FOUNDATION

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INTERNAL GRANT REQUEST APPLICATION FORM

UMCNO Department: Department Supervisor:

Address: City: State: Zip Code:

Phone: Fax: Email:

Project Contact Person/Title/Phone/Email *(if different from above):*

Project Title:

Summary of Project *(limit to 400 characters):*

Indicate Zone of Interest *(Select only one)*:

___ Patient Family Assistance ___Patient Education ___Staff Education ___Patient Medication

___ Medical Research ___ Medical Equipment ___ Other Equipment

Type of Support Requested:

___ Existing Program ___ New Program ___ Planning Grant

___ Research ___ Other *(describe)*: _____

Project Time Line: Start Date: _____ End Date: _____

Total SOCF Amount Requested
$_____

Total Cost for this Project
$_____

List Other Organizations Solicited for this Project	Amount Requested	Date Requested	Amount Approved/Received

_____ _____

Signature of Supervisor *(or signing authority)* Print Name

_____

Date