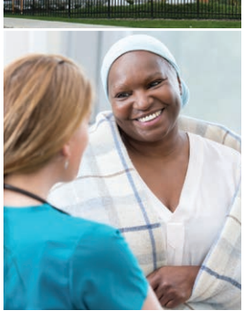
CAMC Foundation

Grant Application









Date:_____ Department Name: _____

Applicant (employee name):_____

Applicant phone number:_____ Applicant e-mail: _____

Department Address:_____

_____

Dept. Charge Number: _____ Dept. Manager:_____

**Amount of Grant Request:$**\_\_\_\_\_ Total cost of Project:$ _____

Describe the project:_____

_____

_____

_____

_____

_____

How will this project benefit CAMC?_____

_____

_____

_____

What patient base will be served if the project is funded?_____

_____

_____

_____

CAMC Strategic Initiative to which project relates:

- ☐ Best place to receive patient-centered care
- ☐ Best place to work
- ☐ Best place to practice medicine
- ☐ Best place to learn
- ☐ Best place to refer patients/market growth

Applicant: _____

Signature (Typed if submitting electronically)

Your Manager: _____ Your Administrator: _____

Signature Signature

* Please attach quotes for costs if applicable.
* Please attach photos if applicable.
* Please attach budget for the project
* Please attach additional pages, if needed for your narrative