CAMC Foundation

Grant Application

Please Print

Date:____________________ Department Name: ____________________

Department Address:____

____

Department Charge Number: ____

Applicant (employee name):____

Applicant phone number:____________ Applicant e-mail: ____________

**Amount of Grant Request:$**____________ Total cost of Project:$ ____________

Describe the project:____

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How will this project benefit CAMC?____

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

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What are the outcomes or results expected should this project be funded?____________

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* 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

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:____________________ ____________________

Print Signature (Typed if submitting electronically)

Please List: Your Manager: ____________________ Your Administrator: ____________________