

# Michigan Pharmacy Foundation Grant Application

*Please complete the following application.*

Application Date:

## Applicant Information

Name: (First)                      (Middle Initial)                      (Last):

Title and Degrees:

Name of Practice/Organization:

Mailing Address:

City:                      State:                      Zip:

Business Phone:

Home Phone:

Cell Phone:

FAX Number:

E-mail Address:

## Project/Program Details

Project/Program Title:

Brief Description / Goals of the Project/Program (Limit to 250 words)

Rationale and Anticipated Significance to MPF and/or the Profession of Pharmacy (Limit to 250 words)

Describe the Project/Program Design (Limit to 250 words)

Describe Anticipated Outcomes and Evaluation Strategy (Limit to 250 words)

Timeline of Project/Program:

Anticipated Start Date:

Anticipated Completion Date:

## Financial Specifics

Amount of Funding Requested from the Michigan Pharmacy Foundation: \$

Total Funding Required for Project/Program: \$

Please provide a detailed budget by completing the following table.

Financial Description	Amount Required for Project	Amount Requested from MPF	Amount Requested from Others
Personnel Wages			
Professional or Consultant Fees			
Materials/Supplies			
Printing & Copying			
Telephone & Fax			
Postage & Delivery			
Rent			
Utilities			
Evaluation			


Have you obtained financial support from any other organization or business?

Yes  No

If yes, please indicate the name(s) of the organization(s) or business(es) funding your program/project and the amount of funding you have obtained from each organization.

Name of Funding Organization	Dollar Amount Provided by Organization/Business

If 100% of the funding required for the project/program is not obtained, will the project/program still be conducted?

Yes  No

Will this project/program be self-sustaining when grant funding is exhausted?

Yes  No

### Collaborator(s) Information

Name (First) (Middle Initial) (Last):

Title and Degrees:

Name of Practice/Organization:

Mailing Address:

City: State: Zip:

Business Phone:

Home Phone:

Cell Phone:

FAX Number:

E-mail Address:

Role in Project/Program:

Name (First) (Middle Initial) (Last):

Title and Degrees:

Name of Practice/Organization:

Mailing Address:

City: State: Zip:

Business Phone:

Home Phone:

Cell Phone:

FAX Number:

E-mail Address:

Role in Project/Program:

### For Approved Grant Funding

Please make check(s) payable to:

Name:

Mailing Address:

City: State: Zip:

Social Security Number

Federal Tax Identification Number

How did you hear about the Michigan Pharmacy Foundation Grants?

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Website           | <input type="checkbox"/> MPA Journal |
| <input type="checkbox"/> MPF Annual Report | <input type="checkbox"/> MPA Doses   |
| <input type="checkbox"/> Colleague         | <input type="checkbox"/> Other       |

Please return your completed application to Dianne Miller, MPF Executive Administrator by e-mail at [dianne@michiganpharmacists.org](mailto:dianne@michiganpharmacists.org). Applicants who desire to submit his or her request by postal delivery should submit three hard copies of the application and mail it to Michigan Pharmacy Foundation, Attention: Dianne Miller, Executive Administrator, 815 N. Washington Avenue, Lansing, Michigan, 48906. Please note faxed applications will not be accepted for consideration.