Sarasota Memorial Healthcare Foundation, Inc.

Request for Restricted Funds $25,000 or less

For Use by SMH Departments Only
Please complete all sections fully

Date of request _____ Requesting SMH Depart./ Unit _____

Name & title of requestor _____

Extension _____ FAX _____

E-mail address_____

Department approval: Yes / No **By: Authorized signature**_____

Printed name & title of above _____

Signature of SMH CEO or V.P. _____

Printed name & title of above _____

Explain your specific request and the purpose of proposed program/project, including
***travelers names* and *dates of travel – attach copies of conference agenda/itinerary*:**

Give an expected time line for the implementation and completion of the program or project:

What is the budget for the program or project for which you are applying for funds and how will they be used?

What is the total program or project cost? $_____

What is the amount you are requesting? $_____

What other sources of funds are available for the program or project? _____

_____

Have you applied to another organization for this funding? Yes ____ No ____
If "yes", name of organization: _____

Has the equipment already been ordered or purchased? Yes____ No____

NOTE: Within 30 days of completion of travel or project, recipients of educational grants are asked to submit a short report to the Foundation describing the benefits received from the program

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For Foundation Use Only: Grant Request # 01- _____ ***Approval date***_____

By _____ ***Source & date funds transferred***_____

rev. 9/01/17