

KENT MEDICAL FOUNDATION
APPLICATION FOR FUNDS

Applicant(s) Name(s): _____ Local/cell Phone: _____

Affiliation/school: _____ Abstract title of project: _____

Local Address: _____

Fax: _____ Email: _____

Current Membership(s): AMA Yes No MSMS Yes No KCMS Yes No

List any previous support from this funder in the last five years: _____

Abstract title/Project Name: _____

Purpose of Grant NOTE: If you are not the presenting author, please describe your interest pertaining to the conference:

Dates of the Project: _____ Amount requested: _____

Conference location: _____ Date of Meeting: _____

Name of Conference: _____ Sponsor agency: _____

Budget (org. only) \$ _____

Partner agencies, others to involve:

Amount Requested: \$ _____, is this partial funding? Yes No

Other funding alternatives approached:

- Hospital Med-Ed budget
- GR Medical Education Research Consortium
- Pharmaceutical/Medical Equipment company
- Hospital Foundation medical education funds

Please thoroughly articulate the following areas as they relate to your grant. This application may be downloaded via the Kent County Medical Society (KMF) website at www.kcms.org.

Abstract should be presented to the KMF Board for consideration:

- **Project Narrative - Description of Program, Audience, Need**
- **Expected Outcomes and Measurements of Success**
- **Organization Structure**
- **Summary of Ongoing Programs**
- **Community Partners who have invested with or partnered with you**

FOR BOARD AND OFFICE REVIEW– DO NOT WRITE IN THIS BOX:

1. Applicant status: Med Student Resident Physician Attending Physician
 Other _____
2. Request: Community Service Research grants Student tuition/loan
3. Project meets guidelines: Yes No Suggested alterations: _____

4. Project requires IRB approval: Yes No Timeline: _____
5. Have other alternatives to funding been pursued: Residency program, hospital, etc.
Which:
