S-3

VOLUNTEER ASSOCIATION ADVISORY COUNCIL

GRANT REQUEST

Date _____ Name _____

Email _____ Title _____

Phone _____ Name of Department _____

REQUEST: PATIENT/FAMILY NEED __ / STAFF SUPPORT __ / COMMUNITY SERVICE __ / EDUCATION __

Describe the program/project associated with the request and how it will benefit patients, community, staff and/or department being served. (Please attach additional information if necessary.)

Clearly state the goals you hope to achieve.

Is this a pilot project? If not, how long will the program/project last?

A final report is required within 90 days of the completion of the program.

Units needed _____ Cost/Unit _____ Total Cost _____ (include freight)

Signed by Requestor _____

Signed by Supervisor _____

NOTE: Please attach estimates from vendors for requests over $500.00.

Revised 3/06; 1/08; 6/08; 1/09; 8/12; 1/13; 6/13; 5/14; 10/14