WESTERN MICHIGAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS COMMUNITY SERVICE GRANT

The Western Michigan Society of Health-System Pharmacists (WMSHP) provides financial support for WMSHP members and pharmacy students interested in conducting community service projects that fulfill the Society's purpose of advancing public health, patient care, and the interests of the pharmacy profession in Western Michigan.

WMSHP community service grant applications may be submitted at any time. Applications should be submitted via email to the current WMSHP President-Elect (contact information available at www.wmshp.net/board/). Applications will be reviewed for completeness and then submitted to the WMSHP Executive Board for review and funding consideration. Applicants may be asked to provide additional information and/or attend a monthly board meeting to present their project and answer questions. Depending on the time of submission, applications may take 1 to 3 months to process.

Grant requests may be fully funded, partially funded, or denied. Grantees will be required to submit a final report after completion of the project. In addition, grantees may be requested to attend a board meeting to present project outcomes or communicate the value of the project to the WMSHP Board and/or WMSHP members.

WESTERN MICHIGAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS
COMMUNITY SERVICE GRANT APPLICATION

Application Date: _______________________

Applicant Information

First Name: ______________________ Middle Initial: _____ Last Name: __________________________

Title and Degree(s): ____

Practice Site/Organization: ____

Mailing Address: ____

City: ______________________________ State: ____________________ Zip Code: ________________

Business Phone: _____________________________ Home Phone: ______________________________

Cell Phone: _______________________________ Fax Number: _________________________________

E-mail Address: ____

Project Details

Project Title: ____

Brief Description of Project Goals (please limit to 250 words)

Brief Description of Project Design (please limit to 250 words)

Anticipated Benefit to WMSHP and/or the Profession of Pharmacy (please limit to 250 words)

Anticipated Outcomes and Evaluation Strategy, If Applicable (please limit to 250 words)

Project Timeline

Anticipated Start Date: ______________________ Anticipated Completion Date: _____________________

Collaborator Information

**For projects conducted by student organizations, please include faculty advisor information here.*

First Name: ______________________ Middle Initial: _____ Last Name: __________________________

Title and Degree(s): ____

Practice Site/Organization: ____

Mailing Address: ____

City: ______________________________ State: ____________________ Zip Code: _________________

Business Phone: _____________________________ Home Phone: ______________________________

Cell Phone: _______________________________ Fax Number: _________________________________

E-mail Address: ____

First Name: ______________________ Middle Initial: _____ Last Name: __________________________

Title and Degree(s): ____

Practice Site/Organization: ____

Mailing Address: ____

City: ______________________________ State: ____________________ Zip Code: _________________

Business Phone: _____________________________ Home Phone: ______________________________

Cell Phone: _______________________________ Fax Number: _________________________________

E-mail Address: ____

First Name: ______________________ Middle Initial: _____ Last Name: __________________________

Title and Degree(s): ____

Practice Site/Organization: ____

Mailing Address: ____

City: ______________________________ State: ____________________ Zip Code: _________________

Business Phone: _____________________________ Home Phone: ______________________________

Cell Phone: _______________________________ Fax Number: _________________________________

E-mail Address: ____

Financial Specifics

Amount of Funding Requested from WMSHP: $____________

Total Funding Required for Project: $____________

Please provide a detailed budget by completing the following:

Financial Description	Amount Required for Project	Amount Requested from WMSHP
TOTAL		

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 project and the amount of funding you have received from each organization.

Name of Funding Organization	Dollar Amount Provided by Organization/Business

For Approved Grant Funding

Please make check(s) payable to: ____

Name: ____

Mailing Address: ____

City: ________________________________ State: _____________________ Zip Code: __________________

Social Security Number: _____________-_________-_______________

Federal Tax Identification Number: ____

Submit completed applications via email to the current WMSHP President-Elect (contact information available at www.wmshp.net/board/).