DAKOTA HOSPITAL FOUNDATION

PART A: REQUEST BEING MADE BY

Name of Requesting Individual, Group, Organization

Address

City State Zip

Contact Person Phone Email

$_____ Amount Requested

Program/Project Title

PART B: PROJECT DESCRIPTION (Briefly summarize the purpose of your request.)

PART C: (Briefly describe the use of the funds and how you will measure the effectiveness of your activities.)

PART D: (Please list funding sources to date)

Funding sources to date	Amount	Date Received

PART E: (Please list funding sources that are pending)

Funding sources pending	Amount	Date Expected

PART F: (Please provide the timeline for project completion.)

_____
_____
_____
_____
_____

I acknowledge that all the information provided in this grant application is true and correct to the best of my knowledge. I also certify that I have the authority to request these funds and certify that the funds will be used solely for the purpose described herein. I agree to furnish additional information as requested by the Dakota Hospital Foundation.

_____ _____ _____

Authorized Signature and Title Date

SEND COMPLETED APPLICATION TO:

Dakota Hospital Foundation
20 South Plum Street
Vermillion, SD 57069