Grant Request Instructions

Request Letter

All grant requests must be accompanied by a Request Letter that is on the requestor's letterhead, dated, signed by an authorized representative, and contains all of the requirements listed below:

- ☐ The grant requestor's name, signature, email address, fax number and phone number.
- ☐ The grant requestor's tax identification number.
- ☐ The date of the letter (the letter must be dated and received by the ACIST Grant Review Committee at least 60 days prior to the date of the program or event for which the grant is requested.
- ☐ The topic, objective, and description of the activity for which the grant is requested.
- ☐ The agenda or proposed agenda of the activity.
- ☐ The location where the activity will be held, where applicable.
- ☐ The date of the activity, where applicable.
- ☐ The intended audience for the activity.
- ☐ Evidence of accreditation, where applicable, a Grant Request Letter from an accredited provider stating that the provider and program are accredited and indicating the number of credits that will be received is sufficient.
- ☐ Amount, budget and description of how the grant funds will be used, containing adequate detail to determine the reasonableness of the grant request.

Grant Request Instructions

Complete all information and send this form and a Grant Request Letter to:
ACIST Medical Systems, Inc., 7905 Fuller Road, Eden Prairie, MN 55344
Attn: Grant Review Committee

Check Payee:		Date:	
Address to Send Funds: (No PO box)			
Amount Requested:		Tax ID Number:	
Contact Name:		Contact Phone:	
Contact Fax:		Contact Email:	

Type of Requestor

Grants may be only to the individuals/entities and only for the corresponding programs listed below. Check the box indicating the type of requestor you are and the type of program for which you are requesting funding.

☐ Medical/Professional Association, Patient Advocacy Group ☐ Medical Education ☐ Patient Education/Community Related Activities ☐ Scholarship to attend Professional Meeting	☐ Hospital, Community Health Center, Other Healthcare Facility, Academic Medical Center/University ☐ Medical Education ☐ Patient Education/Community Related Activities ☐ Scholarship to attend Professional Meeting
☐ Managed Care Organization ☐ Medical Education ☐ Patient Education/Community Related Activities ☐ Scholarship to attend Professional Meeting	☐ Non-Profit (501(c)(3) Organization
☐ Health Care Professional (Physician, Nurse, Pharmacist) ☐ Accredited Education	☐ Other Organization ☐ Accredited Medical or Healthcare Professional Education ☐ Non-Accredited Medical or Healthcare Professional Education.

I certify that all information provided in this Request Form and accompanying request letter is accurate and complete, and I understand that consideration of my request is <u>not</u> conditioned upon prescribing, purchasing or recommending ACIST products. I further understand that only the ACIST Grant Review Committee can approve a charitable contribution request and make a commitment to provide funding.

Organization Requestor (Print Name)	
Organization Requestor (Signature)	

Internal Use Only		
☐ Approved	☐ Rejected	
Signature: Date:	Signature: Date:	Signature: Date:
Human Resources	**Finance**	**Legal**

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