Pediatric Foundation of Georgia

1350 Spring Street., NW, Ste. 700
Atlanta, GA 30309-2874
404-881-5091

Grant Application Form

Note: Grant requests are considered in June and in October. Applications must be received by May 15 or August 15 for consideration at the next meeting of the foundation board.

Date: _____

Organization: _____

Address: _____

_____

Phone: _____ Fax: _____

Contact Person: _____

Email: _____

Board President/Chair: _____

Medical Director (if applicable)_____

Amount of Request: _____ Total Project Budget: _____

Total Annual Operating Budget - current year: _____

Total Annual Operating Budget – previous year: _____

Mission Statement of applying organization (1-2 sentences):

Description of the project for which funds are being requested: (50 word maximum)

Describe the target population that you plan to serve with the project:

What are 1 or 2 outcomes you expect to occur during the grant period as a result of the services of your program?

Please indicate the Georgia AAP member (pediatrician or pediatric subspecialist) directly involved with your project. Describe their role and attach a letter of support from them. ***Applications will only be considered if there is direct involvement with a Georgia AAP member.***

Add any other comments you believe relevant to your application.

Thank you.