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.

Please complete and send to Michelle Hudson at mhudson@gaaap.org.

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?

Is there a Georgia AAP member (pediatrician or pediatric subspecialist) directly involved in your project?

_____Yes ____No

If yes, please name them and describe their role; and **attach a letter of support from them**.

If your project includes a specific diverse population, please provide more details:

Add any other comments you believe relevant to your application:

Thank you.

Revised 11/21