

# 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 summer and late fall. Applications must be received by May 15 or September 1 for consideration at the next meeting of the foundation board.*

**Please complete and send to Michelle Hudson at [mhudson@gaaap.org](mailto: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**. Please note, preference will be given to applicants with direct involvement with a Georgia AAP member.

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

Add any other comments you believe relevant to your application:

Thank you.