



EDUCATIONAL GRANT & DONATION APPLICATION FORM

This Educational Grant & Donation Application Form is for **Education and Other Charitable Requests** (other than research grants). Applications must be received at least **ninety (90) days** prior to the event occurring for consideration. Also, please note that your application must be submitted with all required documents - please refer to Terumo's email for a list of required documents. Missing or incomplete documents will cause delays and may result in a denial of your application. Additionally, this application process is solely for Educational Grants and Donations, and NOT for sponsorships or exhibit requests. For Sponsorships or Exhibit requests, please contact ExhibitRequests@terumomedical.com.

APPLICANT INFORMATION

Date: **Name of Person or Organization:**

Organization Contact: **Title:**

Address: **City:** **State:** **Zip:**

Tel. No.: **Email:** **Website:**

Social Security or Federal Tax ID Number:

PROGRAM INFORMATION

Name of program/initiative for which support is requested:

Total Amount of Funding Requested: **Amount \$:**

Total Budget for Program/Initiative: **Amount \$:**

Name of Organization's Financial Institution where Terumo's financial support would be deposited:

Brief description of program/initiative:
- Please attached the detail narrative of the program/initiative to this application

Brief Description:

By checking this box, I am indicating that I have attached the **detailed narrative of the program/initiative** to this application

Please indicate how the requested support furthers the Charitable Mission and Charitable Focus (as expressed in the Grants & Donations Policy) of TMC:

List other current sources of funding:

Indicate if the applicant received any previous funding from TMC or its affiliates and the relevant amount(s) of funding and date(s):

| | | | |
|-------------------|----------------------|--------------|----------------------|
| Amount: \$ | <input type="text"/> | Date: | <input type="text"/> |
| Amount: \$ | <input type="text"/> | Date: | <input type="text"/> |
| Amount: \$ | <input type="text"/> | Date: | <input type="text"/> |

Is the organization (or parent organization) on the United States CMS Open payments List of Teaching Hospitals? Yes No

Is the organization owned and/or controlled by a health care professional?

Yes

No

PROGRAM ACTIVITIES and DELIVERY FORMAT

Under this section you are required to provide a general description of the activities which are part of the program (i.e., live or web program), including those for which Terumo's support is sought, and the delivery format (e.g., live case, didactic session, hands-on workshop, etc.)

Delivery Format Type:

Delivery Format (specify if Live or Web):

- If **Live**: indicate if it is a hands-on workshop, satellite symposia, symposia, research conference, lectures, didactic sessions, live cases

Live :

- If **Web**: online education/training module, webcast/live program or other

Web :

Number of Speakers/Faculty:

Activity Start and End Date:

Start Date:

End Date:

Web URL (optional):

Geographic Reach:

Local

Regional

National

International

Audience Generation Tactics:

Audience Group:

-e.g. Physicians (i.e., Interventional Radiologists, Interventional Cardiologists), Nurses, Technicians, Fellows, etc.

Specialty:

Category of Credit:

ACCME

AMA

N/A

Other

CE/CME Credit Hours for Category:

Number of credit hours available for this specific activity:

hours

BUDGET:

-the budget for the event shall include, but not be limited to, all costs related to Faculty and Staff, Honoraria, Meals, Meeting Logistics, Content Development, Accreditation Costs, and/or Outcomes.

By checking this box, I am indicating that I have attached the **budget** to this application.

ACCREDITATION DETAILED INFORMATION (IF APPLICABLE)

Is the program accredited?

Yes

No

Is your organization the accreditor?

Yes (please attach a copy of the accreditation certificate)

By checking this box, I am indicating that I have attached a copy of the **accreditation certificate** to this application

No (please provide the Accreditor Organization Name)

Name of the Accreditor Organization:

By checking this box, the applicant certifies that the program is accredited and the organization will abide to all terms and conditions set forth by the accrediting body.

PRODUCT SUPPORT

Are you seeking IN-KIND product support from Terumo for any of the activity described above?

Yes (Please attach a Product Support Form) No

By checking this box, I am indicating that I have attached a **Product Support Form** to this application.

Are you requesting Terumo to loan a Simulator(s)?

Yes (please describe) No

Describe:

Are you requesting Model(s)?

Yes (please describe) No

Describe:

May a clinical specialist be present for Simulator and/or Model Support?

Yes No

ATTACHMENTS WITH THIS APPLICATION FORM

By checking the boxes below, you are indicating that you have attached the required documents to this application.

W-9 (Current)

IRS Letter of Determination (if applicable)

Accreditation Certificate (if applicable)

Detailed Agenda

For live education events, the agenda must include hour by hour detail of all the content to be presented

Letter of Request

Note: this should be a formal letter on your organization's letterhead that describes the program and requested support from Terumo

Invitation Flyer/Marketing Material (optional)

Organization Governing Document

PAYMENT

Is the Payee address the same as the Organization address?

Yes

No (please indicate the address for forwarding financial awards (checks))

Address:

Name (Please print)

Title

Authorized Signature

Date

Organization Name

Date

Applications are accepted throughout the year. Please submit your donation application by email to: grantsanddonations@terumomedical.com

For any questions, please contact: Terumo Medical Corporation, Attention: Grant Review Committee, 265 Davidson Avenue, Suite 320, Somerset, New Jersey 08873 - Phone: (855) 822-0987