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: $ **Date:**

Amount: $ **Date:**

Amount: $ **Date:**

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

☐ **Live :**

☐ **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