

**COLOPLAST CORP.
EDUCATIONAL, FELLOWSHIP, RESEARCH, OR CHARITABLE GRANT REQUEST
FORM**

General Information

Organization Requesting Grant: _____
 Employer Tax I.D. No.: _____ (should match Payee Information)
 Amount of Grant Request: \$ _____
 Request type (educational, fellowship, research, or charitable): _____
 Request Date:**: _____

** Please note that, in general, only grant requests that have been completed in full and received by the Coloplast Corp. Grant Committee **at least sixty (60) days prior** to the start of the program will be considered.

Requestor must submit the following documents or supporting information with this Grant Request; requests submitted without supporting documentation will not be considered and returned to the requestor:

- | | |
|---|--|
| <input type="checkbox"/> W9 Form (Tax ID) | <input type="checkbox"/> Contingency Plans (if full funding is not obtained) |
| <input type="checkbox"/> Program Objectives/Course Agenda (for educational program) | <input type="checkbox"/> Accreditation statement, including approved hours (for educational program) |
| <input type="checkbox"/> Event flyer or brochure (for charitable program) | <input type="checkbox"/> Research Project Plan including Protocol (for research program) |
| <input type="checkbox"/> Budget Information (itemize list of expenses) | |
| <input type="checkbox"/> List of other funding sources | |

Program Information

Program Title: _____
 Program Date(s): _____
 Program Director(s): _____
 Program Description: _____
 Program Location: _____
 Anticipated or Average Number of Attendees: _____

Will intimate healthcare needs such as inflatable penile prosthesis implants, continence, urological, ostomy, skin and wound support be a part of this Program?*: _____

**Please note that grant requests that feature the above support for people with intimate healthcare needs have the best chance of approval by the Coloplast Corp. Grant Committee.*

If "yes", please explain: _____

Educational Program Specific Information

Primary attendees (physicians, nurses, patients, others): _____
 Presentation type (live, teleconference, webcast, CD-ROM, other): _____
 Accreditation Information:
 Accrediting body name: _____
 Number of hours: _____
 Category of credit: _____

Contact Information

	Requestor Information:	Payee Information:
Name:		
Address:		
Primary Contact:		
Phone:		
Fax:		
Email:		

Submission of this Grant Request and the foregoing documentation ***does not guarantee approval*** of the request. Coloplast Corp. will only pay grants upon approval by the Coloplast Corp. Grant Committee and after the Grant Agreement has been countersigned by Coloplast Corp. *The Coloplast Corp. Grant Committee reserves the right to award less than the amount requested.*

The undersigned affirms to the best of his/her knowledge and belief and after reasonable inquiry that the foregoing information is true and accurate and that this grant is not offered to induce use of, purchase of, or recommendation of Coloplast products by a Healthcare Professional. The undersigned also affirms that he/she is authorized to sign on behalf of the Recipient/Payee indicated above.

The undersigned further affirms that any meals and refreshments provided as part of an educational program will be modest in value, subordinate in time and focus to the purpose of the educational program, and clearly separate from the educational portion of the program. In addition, any faculty honoraria, travel, lodging and meal expenses for the educational program covered by the funds from this grant will be reasonable in value. Further, the venue for the educational program will be appropriate to the subject matter and conducted in a setting conducive to the exchange of information.

Signature of Requestor

Date

Printed Name of Requestor

Title of Requestor

Please submit Grant Request and all required documents:

by fax to 612.344.2408 or by email to grants@coloplast.com