



CHARITABLE FUNDS CLIENT INFORMATION WORKSHEET

(PLEASE REFER TO "GUIDELINE TO COMPLETING INFORMATION WORKSHEET")

Name of Applicant: _____ Location: _____ Date: _____

Application Received by: _____

Reason for funding request; be specific; please use another sheet of paper if you need more space on which to make your case:

State your recommendation and please include back up information to justify your request. Also please state which vendor we should forward payment to and include an invoice.

SPACE BELOW RESERVED FOR SEARHC OFFICE USE

Steering Committee Member Approval _____ Date _____ Second Signature, Steering Committee Member _____ Date _____
(for funds approved \$101-\$750)

Signature of VP (for funds over \$750) _____ Date _____

DME (Acct. 6131) Travel (Acct. 6241) Pharmaceuticals (Acct. 6111) Amount: _____
 Approved Declined

Reason for not funding request:
Initials: _____ Date: _____

PLEASE MAIL OR FAX THIS FORM TO: NANCY JO BLEIER
C/O SEARHC MT. EDGE CUMBE HOSPITAL, 222 TONGASS DRIVE, SITKA, ALASKA 99835 FAX (907) 966-8698