# Episcopal Church Women
## Emergency Medical Grant Application

### I. PERSON REQUESTING THE GRANT

NAME: _____

ADDRESS: _____

_____

PHONE: _____ EMAIL: _____

### II. NAME AND ADDRESS OF CHURCH ATTENDING

_____

_____

_____

### III. AMOUNT REQUESTED

_____

### IV. SIGNATURE OF RECTOR DATE

_____ _____

Please mail completed application to:

The Episcopal Church Women
Diocese of Los Angeles
P.O. Box 512164
Los Angeles, CA 90051-0164

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For office use:

Date application received: _____

All information received: yes/no Check #: _____

Endorsement of the ECW Diocese of Los Angeles: _____

Approval Date: _____ Amount: _____

Payment Issued: _____ Date: _____