

# Episcopal Church Women Medical Ministry Grant Application



## I. INSTITUTION REQUESTING THE GRANT

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

CONTACT: \_\_\_\_\_

TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

## II. RELATIONSHIP TO THE EPISCOPAL CHURCH

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## III. PURPOSE OF GRANT

(Please attach background information including how the funds will be used, budget and who will benefit from the grant.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## IV. AMOUNT REQUESTED

\_\_\_\_\_

## V. HOW DOES THIS PROGRAM CARRY OUT THE MISSION OF THE EPISCOPAL CHURCH?

\_\_\_\_\_

\_\_\_\_\_

VI. ADDITIONAL INFORMATION

Have you applied or will you be applying for a grant to another agency? \_\_\_\_\_  
(If yes, please provide the agencies name and address)

\_\_\_\_\_  
\_\_\_\_\_

If this grant is awarded, to whom should the check be payable and where should it be mailed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Note to Applicants: Traditionally, the recipients of the ECW Los Angeles Medical Ministry Grant prepare a written report of how their grant was used for publication in the Episcopal Church Women's periodical, the Communiqué. Your written report will help promote and advertise this program throughout the Diocese of Los Angeles and spread the word to other potential candidates for this grant. Mention of the ECW in your publicity is greatly appreciated.*

VII. SIGNATURE OF REQUESTOR

DATE

\_\_\_\_\_  
\_\_\_\_\_

**Please mail completed application to:**

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

For office use:

Date application received: \_\_\_\_\_ Application #: \_\_\_\_\_

All information received: yes/no \_\_\_\_\_

Endorsement of the ECW Diocese of Los Angeles: \_\_\_\_\_

Approval Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Check #: \_\_\_\_\_

Recipient Notified: \_\_\_\_\_ By: \_\_\_\_\_

Payment Issued: \_\_\_\_\_ Date: \_\_\_\_\_