Application Checklist: (Incomplete applications will not be considered.)

☐ *Completed Application (All Requests)*

☐ *Formal Letter of Professional Program Acceptance (Education Requests)*

☐ *Official Transcript (Education Requests)*

☐ *Proposal Summary (All Requests)*

☐ *4+ year course of study: Requirement of 1 year of college completed.*

☐ *2+ year course of study: Requirement of 1 semester completed.*

MEADOWS MEMORIAL FUND

Grant dollars are available to those needing financial assistance for: **Healthcare Education or Training, Preventative Health Education Programs, and/or Medical Equipment**. The committee places emphasis on educational needs over equipment and first consideration is given to those applicants in the Carrington Medical Center Service Area. Funding will not go towards bricks and mortar, repayment of school loans, or patient medical bills.

PERSONAL / ORGANIZATIONAL INFORMATION

*Person or Organization including email address **(required)*** *Telephone*

Mailing Address *City* *State* *Zip*

Name of top management, if organization (CEO, President, Executive Director, Board Chair) *Title* *Telephone*

Contact Person *Telephone*

GRANT CATEGORY APPLYING FOR:

❑Education Scholarship Assistance for HealthCare Professional Program (must be formally accepted)
❑Financial Assistance for Medical Training (must be formally accepted)
❑Professional Training that will support healthcare in the Carrington Medical Center Service Area
❑Preventative Health Care Education
❑EMS Assistance (equipment only, not operations)
❑Healthcare Enhancement Equipment (not bricks and mortar)

FINANCIAL INFORMATION:

Amount Requested $_____
Total Project Cost including Amount Requested $_____
Total annual budget (organizational applications only) $_____

The duration over which the dollars will be used ❑Immediately, ❑Years_____, ❑Months_____

PROPOSAL SUMMARY/NARRATIVE: Use back side of application or attach additional paper. Be very specific as to what the funds will be used towards (what piece of equipment; what educational fees, etc.), the purpose of the request, and the geographic area that will be served. Also if applicable list the number of patients, clients or residents that will utilize equipment or education annually.

FUNDS REQUESTED FOR EDUCATION/TRAINING:

❑Provide copy of official acceptance letter into healthcare related educational program
❑Provide most current grades official transcript
College/University: _____
Projected date of graduation: _____
Major: _____
Do you intend to return to the Carrington Medical Center service area? ❑ Yes ❑ No
Have you discussed your plans to return with any healthcare organization in the Carrington Medical Center service area? ❑ Yes ❑ No If so, with whom: _____

Applicant's signature: _____Date: _____

Return Application to:

Becky Pretzer
Carrington Medical Center
PO Box 461
Carrington, ND 58421
Phone (701-652-7166), Fax (701-652-2884)
Rebecca.Pretzer@commonspirit.org

Deadline Feb 26, 2025