

**St. Clair County Medical Society Alliance  
2016 - 2017 Community Health Grant Application**

Name of Organization \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone # \_\_\_\_\_

Email \_\_\_\_\_

Website \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Federal Tax ID # \_\_\_\_\_

(Please attach verification letter to this application.)

Title of Project \_\_\_\_\_

Requested Funding    \$ \_\_\_\_\_

Describe how the funds granted will be used to impact health, fitness, and health care or promotion.  
(If additional space is required, please attach a separate sheet to this application.)

List the goals of the program or activity and the objectives by which each goal will be achieved and measured for success. (If additional space is required, please attach a separate sheet to this application.)

If this is an on-going program, please give a brief history. (If additional space is required, please attach a separate sheet to this application.)