



Please Return to:
Physician Ambassador's Committee
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ST. ANTHONY'S PHYSICIAN AMBASSADOR'S GRANT REQUEST

ORGANIZING GROUP NAME: _____

PRIMARY CONTACT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ FAX# : _____ E-MAIL: _____

Amount of Grant Request: \$ _____ Name of initiative/program: _____

Is your organization a not-for-profit in the state of Missouri? YES / NO

Please describe how these funds would be used and what they would allow you or your organization to do that you would not otherwise be able:

Would this program require the time or leadership of St. Anthony's Physicians or staff? If yes, please explain.

What geographical area will your program serve? _____

Would St. Anthony's Physician Ambassadors be recognized as a donor to this program? If yes, please explain.

How many individuals and what age groups will your program serve? _____

What aspect of health will your program have an effect on: (i.e. mental health, injury prevention, quality of life, etc.)?

How and when will the effectiveness of your project be reviewed? _____
