MISSISSIPPI SOCIETY OF HEALTH SYSTEM PHARMACISTS
GRANT REQUEST FORM

Name/Organization Requesting Grant: ________________________________

Amount of Grant Request: $_________________
(Attach a copy of proposed grant budget, Please be specific)

Reason for Grant Request:

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CRITERIA
Briefly describe how the proposed project will achieve any or all of the following:

Promote the Profession of Pharmacy:

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Promote Patient Care:

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Support the mission of MSHP:

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Which target of MHSP's goals/objectives does this request support?

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Expected Timeline of Project:

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Additional Information:
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Requested by: ________________________ Date Requested: ____________
Address / Phone: ____

Note: Grant recipients are required to provide a written report to the Committee on Finance on outcomes achieved as a result of this grant no later than six (6) months following receipt of grant. The report should also include specific information on how the money was spent.

Submit this form to:
Treasurer, c/o MSHP, PO Box 4826, Jackson, MS 39296-4826

Completed form must be received BEFORE August 31st of each year.