Michigan State Medical Society Alliance
County Health Grant

Date of Application:____

Name of County:____

Contact Person:________________________Phone:___________________

Address:__________________________City/Zip:______________________

Fax#:_____________________________Email:_______________________

Project Name:____

Purpose of Project: (one sentence):___________________________________

____

Estimated date of project:____

Amount requested:____

Total project cost:____

(executive committee use)

Recommended_____________Not Recommended______________

Date___________________________

Approving officers

____2004-2005