



**Healthy Smiles, Healthy Children
Access to Care Grant Application Cover Sheet**

Grant Requestor Name: _____
Address: _____
Phone: _____
Email: _____

Project Name/Title: _____

Project Dates: _____

Total Amount Requested: _____

Other Sources of Financial Support & Amount (list top five):

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Project Manager Name/Title: _____
Address: _____
Phone: _____
Email: _____

Project Manager CV Appended: Yes _____ NO _____

Participating Dentists (no more than three):

Name: _____
Affiliations: _____
Address: _____
Email: _____
Phone: _____

Fax: _____
Professional Specialties: _____
Years in Practice: _____

Name: _____
Affiliations: _____
Address: _____

Email: _____
Phone: _____
Fax: _____
Professional Specialties: _____
Years in Practice: _____

Name: _____
Affiliations: _____
Address: _____

Email: _____
Phone: _____
Fax: _____
Professional Specialties: _____
Years in Practice: _____

Affiliated Collaborators (list no more than three):
Institution Name: _____
Address: _____

Main Contact: _____
Email: _____
Phone: _____

Institution Name: _____
Address: _____

Main Contact: _____
Email: _____
Phone: _____

Institution Name: _____
Address: _____

Main Contact: _____
Email: _____
Phone: _____

Responsible Officials of Requesting Institution:
Name: _____
Address: _____
Email: _____
Phone: _____
Fax: _____
Signature: _____

Responsible Financial Officer of Requesting Institution:
Name: _____
Address: _____
Email: _____
Phone: _____
Fax: _____
Signature: _____

Signature of Project Manager: _____