Email

APPLICATION FOR RESIDENCY OR FELLOWSHIP GRANT

OsteoMed may support extended medical education programs through Residency or Fellowship Grants made to training institutions, healthcare institutions, or professional societies. OsteoMed may not play a role in the selection of HCPs who participate in the supported residency or fellowship program. The selection of participants is at the sole discretion of the recipient institution or society. The grant must be used to support the genuine medical education of a resident(s) or fellow(s) participating in the residency or fellowship program. Recipient (payee) of the grant cannot be an individual HCP; it may only be paid to the institution or residency/fellowship program.

OsteoMed's Grant Committee must review all requests for Residency or Fellowship Grants for legal, compliance, and business appropriateness. Only the Grant Committee has the authority to approve or deny any such request. OsteoMed's Grant Committee ensures that grant-making decisions are appropriately independent from OsteoMed's sales and marketing functions, and ensures that OsteoMed follows all laws applicable to any grant request. Residency or Fellowship Grants may not be based on, or related to, past, present, or future volume of business generated for OsteoMed by the proposed recipient.

Applications for Residency or Fellowship Grants should be submitted for consideration at least ***two (2) months prior*** to the date of the relevant event or program. If you have any questions about your application, please communicate directly with grants@osteomed.com. Please be advised that OsteoMed's sales personnel are not permitted to discuss pending grant or donation applications.

To complete this request, please provide the following information:

PART 1: RECIPIENT INFORMATION		
Grant Recipient: (Legal Name of Organization or Institution)		Tax Identification Number:
Organization NPO# (if applicable): NPI# (if applicable)		
Contact Person Name:		Title:
Address of Grant Recipient:		
Contact Person information:	Phone:	Fax:
	E-Mail:	
Payee *(if different from Recipient above):*		
PART 2 : RESIDENCY/FELLOWSHIP DETAILS		
Title of Residency/Fellowship:		

Email

CME Event **Yes☐ No☐** **If yes, list CME Provider**			
Program Description: **(Attach additional information as needed)**			
Program Start and End Dates			
Amount of Funding Requested:	$	**Total Program Budget:**	$
Purpose of Funding (what does grant cover):			
PART 3: DISCLOSURE INFORMATION			
Is your organization owned or controlled by a Healthcare Professional?	**Yes☐ No☐**		
If yes, please indicate the name of the Healthcare Professional			
Disclose any other known conflict of interest issues here:			

Please attach the following supporting documentation for consideration:

- ☐ **Program accreditation status**
- ☐ **W-9 Tax Form (US)**
- ☐ **Evidence of public or private status (US)**
- ☐ **Faculty qualifications or expertise**
- ☐ **Program detailed budget**
- ☐ **Program candidate selection criteria and/or eligibility requirements**
- ☐ **Program training objectives and/or defined goals**
- ☐ **A written request from requesting recipient organization on its letterhead**

Return completed form and documentation by email to: grants@OsteoMed.com.

By submitting this application, the requesting organization affirms that the foregoing information is true and accurate and that this grant or donation is not offered to induce use of, purchase of or recommendation of OsteoMed products by a HCP. The organization further affirms that any meals and refreshments provided as part of this event will be modest in value, subordinate in time and focused to the purpose of the conference, and clearly separate from the educational portion of the program. In addition, any faculty honoraria, travel, lodging and meal expenses covered by the funds from this grant will be reasonable in value. Further, the venue will be appropriate to the subject matter and conducted in a setting conducive to the exchange of information.

To Be Completed by OsteoMed Grant Committee:

Date Submitted: _____

CCO/Date_____ Approved ☐ Not approved ☐

CFO/Date_____ Approved ☐ Not approved ☐

CEO/Date_____ Approved ☐ Not approved ☐