# Educational Program Grant Application

| Review | | |
|---|---|---|
| Educational program title & type: | | |
| Date submitted: | Program start date: | Budget requested: |

| Applicant Information | |
|---|---|
| Name: | Title: |
| Address *(Include Country)*: | |
| Phone: | Email address: |
| Are you a medical provider? | |
| How would you best describe your institution/organization/facility? | |
| Legal name: | Country: |
| Tax ID number: | Tax status: |
| Mission Statement: | |
| Name: | Title: |
| Email address: | Med Ed partner utilized: |
| Phone number: | Fax number: |
| Mailing address: | |

# Educational Program Grant Application

| Program Information | |
|---|---|
| Therapeutic area: ☐ Orthopedics ☐ Burn Care | Area of interest: |
| What type of educational program will you conduct? | |
| Is this event associated with a Conference? | |
| What are the applicable levels of educational outcomes(s) that the educational program(s) will measure? | |
| Is this educational program(s) related to competencies of a professional study? ☐ Yes ☐ No | |
| Could this educational program contribute to maintenance of certification (MOC) credits? ☐ Yes ☐ No | |
| What method best describes your educational program *(check all that apply)*:<br>☐ In-person: didactic ☐ Virtual ☐ In-person ☐ Lab ☐ Other | |
| Venue for your educational program: | |
| Title of educational program: | |
| Educational program overview: | |
| Learning objectives: | |
| Evaluation plan for program: | |
| Other information necessary for the complete review of the grant request *(indicate if for CE program, # hours, accreditation type commendations, speakers affiliated with CE provider)*: | |
| Planned number of speakers: | |

# Educational Program Grant Application

| List of Speakers | | |
|---|---|---|
| Name: | Academic affiliation: | Area of expertise: |
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| Expectations for speakers qualifications and affiliations *(if speakers are not known)*: | | |
| Will speakers receive a stipend? | | |

| Program Duration and Dates | | |
|---|---|---|
| First program will start on: | Last program will end on: | |
| # of programs supported by grant: | Duration of each live portion: | |
| Total duration: | | |
| Program location(s): | | |
| City | State | Date: |
| | | |
| | | |
| | | |
| Other location information necessary for the complete review of this grant request: | | |

# Educational Program Grant Application

| Audience Information |
|---|
| Target audience: |
| If other, please explain: |
| Is the program open to audience beyond the institution's employees? ☐ Yes ☐ No |
| If no, please describe: |
| Estimated program attendance: |
| List of method(s) to recruit participants to program: |

| Program Cost *(Please include an itemized budget with the completed application)* | |
|---|---|
| Total cost of the program: | Total requested from Vericel: |
| Cost per person: | Cost per hour of program: |
| Total number of sponsors (including Vericel): | |
| ☐ Other than being directed to Vericel Medical Affairs, I confirm that no Sales or Marketing personnel were involved from Vericel in this grant submission *(please check box)*. | |

| Grant Attachments *(to be completed by grant applicant)* |
|---|
| ☐ Letter of request *(please include signed copy on organizational letterhead)* |
| ☐ Itemized budget |

I understand and agree to report all serious adverse events as required by regulatory authorities.
I verify by signature below that the above statements are true and that I am in good standing with all regulatory authorities:

| Signature: | Printed Name: | Date: |
|---|---|---|
| | | |