

# Foundation for Seacoast Health

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## WORKFORCE DEVELOPMENT APPLICATION SUBMISSION DEADLINE~ April 1<sup>st</sup>

ORGANIZATION NAME \_\_\_\_\_ Tax ID # \_\_\_\_\_

ADDRESS \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

EXECUTIVE DIRECTOR \_\_\_\_\_

CONTACT NAME (if different) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PROVIDE A BRIEF HISTORY AND DESCRIBE CURRENT SERVICES PROVIDED BY THE ORGANIZATION

\_\_\_\_\_  
\_\_\_\_\_

PLEASE PROVIDE A BRIEF DESCRIPTION OF THE WORKFORCE DEVELOPMENT INITIATIVE/PROGRAM/TRAINING FOR WHICH YOU ARE REQUESTING FUNDING. MAKE SURE YOU INCLUDE HOW THIS PROJECT WILL IMPACT YOUR ORGANIZATION AND THOSE YOU SERVE.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WILL THIS RESULT IN A STAFF MEMBER OR MEMBERS RECEIVING A CREDENTIAL OR PROFESSIONAL CERTIFICATION OF SOME FORM?  YES  NO

IF YES, PLEASE PROVIDE THE NAMES OF EACH INDIVIDUAL STAFF MEMBER AND THE CREDENTIAL TO BE RECEIVED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME AND ADDRESS OF ORGANIZATION OR INSTRUCTOR THAT WILL PROVIDE THE TRAINING:

ORGANIZATION/INSTRUCTOR NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

TRAINING SCHEDULE \_\_\_\_\_

\*\*If you have a signed agreement with the organization or instructor, please submit a copy with this application.

TOTAL AMOUNT REQUESTED: \_\_\_\_\_ NUMBER OF EMPLOYEES BENEFITING FROM TRAINING: \_\_\_\_\_

*Maximum request \$2500.00*

COST PER PARTICIPANT: \_\_\_\_\_ ANNUAL COST IF MULTI-YEAR PROGRAM: \_\_\_\_\_

AUTHORIZED SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_