Foundation for Seacoast Health

100 Campus Drive, Suite One ◆ Portsmouth, NH 03801 (603) 422-8200 ◆ Fax (603) 422-8207 ◆ email fsh@communitycampus.org

WORKFORCE DELOPMENT APPLICATION

SUBMISSION DEADLINE~ April 1st

ORGANIZATION NAME _____ Tax ID #_____

ADDRESS _____

Street

_____

City State Zip

EXECUTIVE DIRECTOR _____

CONTACT NAME (if different) _____

E-MAIL ADDRESS _____ TELEPHONE_____

PROVDE 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.

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_____

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: _____