

# Florida Dental Health Foundation

## Project SELECT Grant Application Form

Applicant (Institution/Dental Society): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ email: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Program Director (Grantee): \_\_\_\_\_

Address: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*Please provide proof of non-profit/tax exempt status

### Program Enrollment:

Current Enrollment: \_\_\_\_\_ Previous Enrollment \_\_\_\_\_

Graduates: \_\_\_\_\_ Applicants: \_\_\_\_\_

**Amount of matching funds requested:** \$ \_\_\_\_\_

Applicant's source for matching funds (Check appropriate boxes.)

- Institute/Dental society fiscal budget \_\_\_\_\_
- Private Contributions \_\_\_\_\_
- Other Grants \_\_\_\_\_
- Other Sources \_\_\_\_\_

### Budget outline

#### INCOME:

Project SELECT grant request \_\_\_\_\_

Institution funds \_\_\_\_\_

Dental society funds \_\_\_\_\_

Other \_\_\_\_\_

**Total** \$ \_\_\_\_\_

#### EXPENSES:

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

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**Total**

**\$** \_\_\_\_\_

**Reason for requesting grant:** \_\_\_\_\_

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**Provide a brief history of project:** \_\_\_\_\_

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\_\_\_\_\_  
Signature of Applicant Representative

\_\_\_\_\_  
Date

Completed applications or questions should be directed to:

Florida Dental Health Foundation  
Grants Department  
1111 E. Tennessee Street, Tallahassee, FL 32308  
(850) 681-3629 Fax: (850) 681-0116