



**ST. FRANCIS HEALTHCARE FOUNDATION
PHYSICIANS MEDICAL MISSION FUND APPLICATION FORM**

1. NAME _____ TODAY'S DATE _____

2. POSITION/TITLE _____

DEPT/CAMPUS _____

TELEPHONE: _____ E-MAIL _____

3. DATE/LOCATION OF MISSION TRIP _____

NAME OF HOST/ORGANIZATION SPONSORING TRIP _____

BRIEF DESCRIPTION OF HOST/ORGANIZATION _____

4. DESCRIBE THE TRIP AND HOW IT WILL SUPPORT THE HOSPITAL'S MISSION AND GOALS.

5. AMOUNT OF FUNDS REQUESTED _____

DESCRIBE HOW THE FUNDS WILL BE USED (I.E. TRAVEL, SUPPLIES, ETC.) _____

DESCRIBE WHO WILL BE USING THE FUNDING IF OTHER THAN THE APPLICANT.

IS FUNDING ASSISTANCE AVAILABLE TO YOU THROUGH THE HOST/ORGANIZATION? IF YES, PLEASE DESCRIBE.

**APPLICATIONS ARE DUE MAY 1 AND NOVEMBER 1.
COMPLETED APPLICATIONS SHOULD BE ADDRESSED TO:**

ST. FRANCIS HEALTHCARE FOUNDATION
5255 E STOP 11 ROAD, STE. 245
INDIANAPOLIS, IN 46237
ATTN: PHYSICIANS MEDICAL MISSION FUND
TEL: (317) 783-8949 FAX: (317) 782-6521 E-MAIL: MARK.PFLUM@SSFHS.ORG

5.15.09
AEH