Rock Medical Foundation

Funding Application

Name(s): _____

Main contact email: _____

Main contact phone: _____

Please describe the relationship to Rock Medical, Inc.

_____
_____
_____
_____
_____

Please describe the purpose of application.

_____
_____
_____
_____
_____

How is the Rock Foundation's mission aligned to your purpose?

_____
_____
_____
_____
_____

Total amount requested: _____

Would you consider partial funding? _____

What are other potential sources of funding?

_____
_____
_____
_____
_____

Please provide a summary describing the goals of this project.

_____
_____
_____
_____
_____

Is there a website or other sources for the board to gain further information?

_____
_____
_____
_____
_____

Why is this project important to you? Why do you think Rock Foundation should fund it?

_____
_____
_____
_____
_____

Please provide a budget breakdown of how funds will be used.

_____
_____
_____
_____
_____

Applicant signature: _____

Date: _____

Please scan the above application and email to foundation@rock-med.com ***or***
drop off application at the Rock Medical Office located at 571 Boston Mills Road, Suite 100, Hudson, OH 44236.