

PARTNERS for Equity in Child and Adolescent Health
Emory University School of Medicine
Department of Pediatrics
Comprehensive School-Based Health Center Program
Grant Application Form

Date of Application:		
Organization Official Name:		
Otherwise Known as (DBA):		
Organization EIN#:		
Name & Title of Person to Contact Regarding this Proposal:		
Email Address:		
Telephone Number:		
Fax Number:		
Address:		
City:	State:	ZIP:
Amount Requested:		
Total Project Budget:		

Overall Organization Budget:

Organization Mission Statement:

Please summarize your request (one to three sentences):