The Hitchcock Foundation

One Medical Center Drive

Lebanon, NH 03756

APPLICATION FOR THE SUSAN A. REEVES ADVANCED PRACTICE PROVIDER GRANT COVER PAGE

|  |
| --- |
| **Title of Project:** |
| **The project is:** | [ ]  Quality Improvement | [ ]  Research |
| **The project will use human subjects:** [ ]  **Yes** [ ]  **No** |
| **The project will use or disclose Protected Health Information (PHI):** [ ]  **Yes** [ ]  **No** |
|  |  |
| **Budget Amount Requested:** | $ | *Not to exceed $30,000.* |
| **Dates of Project (MM/DD/YY):** | Begin: | End: |
|  |  |
| **Principal Investigator (PI)/Applicant:** |  |
| **PI Degree & Position Title:** |  |
| **PI Email & Telephone:** |  |
| **PI Meets Eligibility Requirements:** | [ ]  **Yes** [ ]  **No** |
| **PI % Effort:** |  | *Grant Funds may be used to support up to 10% of PI time.* |
|  |  |
| **Department:** |  | **Dept Chair:** |  |
| **Section:** |  | **Sect Chief:** |  |
|  |  |
| **Mentor Name, Degree & Title:** |  |
|  |  |
| **Sub-Investigator Name, Degree & Title:** |  |
|  |  |
| **Sub-Investigator Name, Degree & Title:** |  |
| [ ]  Sub-Investigator(s) is **not** named in another application being submitted this cycle |

I acknowledge and understand the terms and conditions of this application.

Applicant (PI) Signature:

Institutional Approval:

 Department Chair Signature Printed Name

Institutional Approval:

 Practice Manager or Nurse Manager Signature Printed Name

 (if requesting protected time)