

DENIS A. RADEFELD, M.D. HUMANITARIAN AWARD APPLICATION
COMMUNITY HEALTH PARTNERS REGIONAL FOUNDATION
Application deadline: April 20, 2009

Introduction - Community Health Partners Regional Health System and the Foundation are proud to honor Dr. Radefeld through this special humanitarian award. This award will provide a Community Health Partners' employee with a stipend for qualified expenses to participate in a project that provides direct care to the poor and underserved. This award is not restricted to clinical staff; however, applicants must demonstrate they will be involved in providing direct care. Applicants may be invited to make a personal presentation to the committee. *This award may be taxable as regular income.*

Instructions – Type or fill out the application in ink (PRINT CLEARLY). Do not write in pencil. Answer every question. Mail applications to CHPR Foundation – 3700 Kolbe Road – Lorain, Ohio 44053. We will not accept applications by e-mail or fax. It is your responsibility to ensure that the application packet is complete, as incomplete applications will NOT be accepted.

Application Documentation (Required)

In addition to this form, your Application Packet must contain:

1. Two letters of support, one from your immediate department supervisor and another at your discretion.
2. A written description of the project, its objectives, historical perspective, motivation, personal history of involvement, and statistics (i.e., numbers served, measured outcomes, etc.).
3. A recent photograph.

Employee Name: _____
Name/Credentials (i.e., RN, etc.) Title/Position

Department Name: _____ Ext. _____ Dept. Cost Center: _____

Home Address: _____ City: _____ Zip: _____

Status: _____ Full-time Shift: _____

_____ Part-time Length of Service (including LCH/SJH time)

_____ Years _____ Months

PROJECT / PROGRAM

Proposed Project / Program: (**NOTE:** The project must be approved prior to applicant screening.)

A. Project name: _____

B. Sponsoring Organization: _____

C. Organization contact person: _____ Phone No.: _____

D. Date & location of project service delivery: _____

PROPOSED EXPENSES TO BE COVERED:

Expenses, which may be covered by the award, include room, meals, and travel directly related to the project. *Clothing and personal equipment do not qualify.*

<u>Item</u>	<u>Cost</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
Total request: \$ _____	

I grant the Community Health Partners Regional Foundation permission to use my photograph in any future brochures.

Applicant's signature: _____ Date: _____

Updated: January 27, 2009