



Gary Haigh EMS Scholarship Application

Date of Application: _____

Rural Health Care
Organization Requesting Funds: _____

Address: _____
Street/P.O. City State Zip

Contact Person's Name: _____ Phone: _____

Contact Person's Position or Title: _____

Email: _____

Type of request: Employee or Volunteer Training Continuing Education Program

Total training cost:	\$ _____
Amount of funding already available:	\$ _____
Amount requested:	\$ _____

Project description: *(include specific use of funds. May attach an additional sheet or budget.)* _____

Date funding needed by: _____

for Billings Clinic Foundation office use only

Action by Scholarship Committee
Date: _____ Approved Funding: \$ _____ Not Approved

Action by Foundation
Date: _____ Approved Funding: \$ _____ Not Approved

President's Signature: _____ Date: _____

Please return completed application to:
Billings Clinic Foundation
P.O. Box 31031 Billings, MT 59107
If you have questions, please call: 406-657-4642 or e-mail: jdodd@billingsclinic.org
APPLICATIONS MUST BE RECEIVED BY November 9, 2011