

# Request for Educational Grant

Arthrex, Inc. 1370 Creekside Boulevard • Naples, Florida 34108



Arthrex may provide funding of educational grants to independent, educational, scientific, or policymaking conferences to approved institutions/ organizations or accredited programs in order to support the general medical training of health care professionals and to promote scientific knowledge, medical advancement, and the delivery of effective health care. No direct payment will be made payable to an individual or health care professional.

Educational grants may not be based on, or related to, past, present, or future volume of business generated for Arthrex by the proposed recipient. Any evidence that suggests that the request for an educational grant is tied, in any way, to past, present, or future volume of business will cause the request to be rejected and the request may not be resubmitted.

## To complete this request form you will need the following information:

1. Federal tax ID number for your organization (US)
2. Organization information, including your mission statement
3. Program/event/educational tool information (if applicable)
4. Valid email address for communications
5. A list of your organization's Board of Directors and Executive Officers
6. Documentation verifying accreditation
7. Current IRS form W9 for grant recipient (US)
8. Evidence of public or private status for grant recipient (non-US)
9. Disclosure information related to any HCP-owned or -controlled organization or any other known conflict of interest

## Part 1: Recipient Information *(Arthrex does not fund capital projects)*

Grant Recipient (legal name of organization or institution):		Tax Identification Number:		
Name:	Phone Number:	Email:		
Grant Recipient Street Address:		City:	State:	Zip Code:
Payee (if different from recipient above):				

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Part 2: Program/Event Details	
Title of Program/Event:	
CME Event? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, CME Provider:
Program/Event Description:	
Program/Event Start Date:	Program/Event End Date:
Amount of Funding Requested:	Total Event/Program Budget:
Purpose of Funding (what does grant cover):	

Part 3: Disclosure Information
Is your organization owned or controlled by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate the name of the health care professional:
Disclose any other known conflict of interest issues here:
<b>Please attach the following supporting documents for consideration:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Program brochure/agenda for third-party conference support (draft copies are acceptable)</li><li><input type="checkbox"/> W9 tax form - attached (US)</li><li><input type="checkbox"/> Evidence of public or private status (non-US)</li><li><input type="checkbox"/> Documentation verifying accreditation as applicable</li><li><input type="checkbox"/> Program/event/educational tool detailed budget</li><li><input type="checkbox"/> List of other sponsors for the program/event/educational tool</li><li><input type="checkbox"/> Current list of Board of Directors or Executive Officers</li></ul>
Save and email completed form and documentation to: <a href="mailto:Grants@Arthrex.com">Grants@Arthrex.com</a>