DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

2021 Health Professionals Clinical Training Expansion Grant Program
GRANT APPLICATION FORM

1. Applicant Program (this information will be used in drafting the grant contract)

Legal Name

D.B.A.

Address

City **State** **Zip**

SWIFT Vendor ID No. **Location Code**

Health Clinical Training Professions: (Eligible specialties include: advanced practice registered nurses, dental therapists and advanced dental therapists, Mental health professionals as defined under Minnesota Statute 245.462 Subdivision 18, pharmacists, or physician assistants)

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2. Primary Contact for Project Administration

Name

Title

Address

City/State/Zip

Phone **Email address**

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3. Fiscal Management Officer of Applicant Program

Name

Title

Phone **Email address**

4. Contact Person for Further Information on the Application (if different from above)

Name

Title

Phone **Email address**

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5. What type of grant is your agency applying for?

Planning Grant (Y/N): _____ (1 year contract period)

Fund request: $ _____

Training Grant (Y/N): _____ (3 year contract period)

Fund request - Year 1: $_____

Fund request - Year 2: $_____

Fund request - Year 3: $_____

Total funding request for Planning & Training Grant: $_____

☐ I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant organization.

Signature of Authorized Official **Print Name** **Title** **Date**

Questions regarding grant application guidelines should be directed to Paia Vang, at paia.vang@state.mn.us or 651-201-3856.