# Foundation for Seacoast Health

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## WORKFORCE DELOPMENT APPLICATION

### SUBMISSION DEADLINE~ April 1st

**ORGANIZATION NAME** _____ Tax ID #_____

**ADDRESS** _____

Street

_____

City State Zip

**EXECUTIVE DIRECTOR** _____

**CONTACT NAME (if different)** _____

**E-MAIL ADDRESS** _____ TELEPHONE_____

**PROVDE A BRIEF HISTORY AND DESCRIBE CURRENT SERVICES PROVIDED BY THE ORGANIZATION**

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**PLEASE PROVIDE A BRIEF DESCRIPTION OF THE WORKFORCE DEVELOPMENT INITIATIVE/PROGRAM/TRAINING FOR WHICH YOU ARE REQUESTING FUNDING. MAKE SURE YOU INCLUDE HOW THIS PROJECT WILL IMPACT YOUR ORGANIZATION AND THOSE YOU SERVE.**

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_____

**WILL THIS RESULT IN A STAFF MEMBER OR MEMBERS RECEIVING A CREDENTIAL OR PROFESSIONAL CERTIFICATION OF SOME FORM? __ ___YES _____NO**

**IF YES, PLEASE PROVIDE THE NAMES OF EACH INDIVIDUAL STAFF MEMBER AND THE CREDENTIAL TO BE RECEIVED:**

_____ _____

_____ _____

_____ _____

**NAME AND ADDRESS OF ORGANIZATION OR INSTRUCTOR THAT WILL PROVIDE THE TRAINING:**

ORGANIZATION/INSTRUCTOR NAME_____

ADDRESS_____

EMAIL ADDRESS_____ TELEPHONE_____

TRAINING SCHEDULE_____

**If you have a signed agreement with the organization or instructor, please submit a copy with this application.

**TOTAL AMOUNT REQUESTED:** _____ **NUMBER OF EMPLOYEES BENEFITING FROM TRAINING:** _____

*Maximum request $2500.00*

**COST PER PARTICIPANT:** _____ **ANNUAL COST IF MULTI-YEAR PROGRAM:** _____

AUTHORIZED SIGNATURE: _____ DATE: _____