APPLICATION FOR MEDICAL GRANTS

Please complete all fields as incomplete applications will not be considered.

Instructions: Please type your response in the open text fields.

Once completed, please submit the application along with the following documents to info@tolmar.ca:

- ☑ Itemized breakdown of the entire budget for the program
- ☑ Meeting agenda or website link if applicable
- ☑ Any relevant documentation related to the proposed initiative (i.e. letter of request, project proposal, etc)

SPONSOR INFORMATION

Institution Name		
Applicant	Title	
	Last name	
	First name	
	Office Phone #	
	Office Fax #	
	Email	
Tax ID number		

PROJECT/EDUCATIONAL ACTIVITY

Title of Project or Activity				
Location of Project or Activity	Location nº 01	Location nº 02	Location nº 03	Location nº 04
Schedule/Timeline	From			
	To			
Objectives of the Medical Activity or Project				
Type of participant/ audience/recipients				
Expected number of participants/audience/ recipients				

February 2022
TPI.2022.3077.v1EN 02/2022

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MEDICAL PROJECT OR ACTIVITY

Describe the medical project or activity and how it will benefit patient care, HCPs' scientific or medical knowledge, or other public health objectives.

MEDICAL PROJECT/ACTIVITY LEARNING OBJECTIVES

Please provide learning objectives or metrics for medical project or activity.

MEDICAL PROJECT/ACTIVITY FORMAT & MATERIALS

Describe format or design of project or activity.

MEDICAL PROJECT/ACTIVITY OUTCOMES

Describe how outcomes will be measured (e.g., scales, tests, surveys, etc.).

EXPECTED OUTCOMES AND KNOWLEDGE TRANSLATION

Describe the results of your medical project or activity. Describe how results of activity will be communicated, shared, implemented to benefit patient care, clinican's scientifcic or medical knowledge or other public health objectives.

NEEDS ASSESSMENT

Describe unmet medical needs related to this project. Please provide reference to previous phase of project if this is a continuation or expansion of an existing project/activity.

February 2022
TPI.2022.3077.v1EN 02/2022

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TYPE OF SUPPORT

Total Budget for the Project/Activity	
Amount requested from Tolmar Pharmaceuticals Canada, Inc Total budget CAN$	
Is there support from other partners?	Yes ◯ No ◯
If yes, please provide the name of the other sponsors and the support requested	
List other sponsors	
Support requested	
Support secured based on total budget at time of application:	
CME provider, if any	

SIGNATURE

The information provided in this application is truthful and complete. If any answer in this application changes I agree to amend the submission in a timely manner.	

Tolmar Canada reserves the right to review this information provided to make a decision based on merit and available budget to support the proposed initiative.

Please note, personal information shared by you may be sent to, stored, or processed in the United States or any other country in which Tolmar Pharmaceuticals Canada or its affiliates, subsidiaries, vendors, or agents maintain facilities. In that case, it is subject to the laws of the country in which it is located. Security measures have been put in place to protect them. We will use, disclose or retain such records only for as long as necessary to fulfill the purposes for which they were collected and to the extent permitted or required by law. For more information, please see our privacy policy available online at: http://www.tolmar.ca/privacy.html

February 2022
TPI.2022.3077.v1EN 02/2022