

NWDA Clinic Grant Application

Application Date _____ Clinic Date(s) _____

Grant Applicant _____ Phone# _____ Email _____

Clinic Location: Facility Name _____

Address _____

Clinician Name _____

Clinician Fee per day _____ x _____ days: _____

Travel _____

Lodging _____

Food _____

Total Clinician fee: _____

Advertising _____ (must advertise to current NWDA members)

Insurance _____

Other expense: _____ (please list)

Total Expense: _____

Income: Participant fees: _____

Auditor fees: _____

Other income: _____ (please list)

Total Revenue: _____

Total Anticipated Profit/Loss: _____

Grant Amount Requested: _____ (no more than one-half of expense, max \$1000)

Anticipated NWDA member participant fee: _____ # of participants: _____

Anticipated NWDA member auditor fee: _____ # of auditors: _____

Non-member participant fees: _____ # of participants: _____

Non-member auditor fees: _____ # of auditors: _____

(NWDA members should be 50% of participants)

Please give a brief description of the program for which you are requesting this grant, including the type of program, (clinic, seminar, camp), level of riders participating, need for this program, and finally, a brief description of the qualifications of the clinician or instructor. (Use another sheet, if needed.)

By accepting this grant I agree to the terms listed above. In addition, I understand I will receive the grant funds after providing a written account to the NWDA Board, to be received by the Scholarship Chairperson within 60 days of the clinic.

Signed _____

Send completed application to: Kathy Roby, 2129 Bel Aire Ave., Duluth, MN 55803, 218-525-6398
kathy2129@gmail.com.

For Board use: rec'd _____ approved _____ notified _____ report rec'd _____ paid ck # _____