

Patient Event Grant Report

SITE INFORMATION

Institution: _____

Contact Social Worker/Nurse/Physician: _____

PROJECT SUMMARY

Project Name: _____

Date of Activity: _____ # of Participants/Targets: _____
DD/MM/YYYY

Project Objectives: _____

PROJECT EVALUATION

What were the results?

What was the feedback from participants/targets?

What was the one most effective activity?

How would you improve the project?

How would you build on these activities?

SIGNATURE

Signature: _____

Name (Please print): _____ Date: _____

Email completed Grant Report to contactus@immunodeficiency.ca

Note: Grant reports must be completed for each project before subsequent applications will be considered.