

Physician Network Grant Application

Physicians in the Network are eligible to receive a grant of up to **\$5,000 Canadian**. You may apply for: the diagnosis and testing of patients with a suspected Primary Immunodeficiency, and physician education. Physician symposia expenses such as conference facilities, audio-visual, printed material, coffee breaks, etc. can be funded under this program. Expenses for travel, hotel accommodations, honoraria, and personnel are discouraged.

Grant applications will be reviewed and you will be advised of the funding decision within 60 days from the date of submission. If approved, appropriate funds will be forwarded to a health care institution or expenses may be paid directly by Immunodeficiency Canada.

Subsequent grants will only be considered after a summary report for the current activity has been received.

Some ideas you might consider are:

Grand Rounds/Physician Symposia

The Academic Director (AD) of these conferences should be an expert in Primary Immunodeficiency. They are aimed to educate primary care physicians, family practitioners, internists, sub specialists, post-doctoral fellows, residents, medical students and the nursing community on the 10 Warning Signs, when to suspect PI in a patient, and how to identify specific defects in diagnosed PI patients.

Physician Education Materials

Primary Immunodeficiency materials including a "What is PI" pamphlet and how the immune system works, the 10 Warning Signs, Red Flags for Physicians, are available. Distribution and handling costs can be included.

Questions about submitting a grant application, the grant application process, or the status of an application should be directed to network@immunodeficiency.ca

Grant funding is contingent on funding availability.

Physician Network Grant Application

SITE INFORMATION

Institution: _____ Date: _____
DD/MM/YYYY

Address: _____
Department

Street Address

City Province Postal Code

Lead Physician: _____
Phone: _____ Fax: _____
Mobile: _____ E-mail: _____

Is the mailing address the same as above? YES ☐ NO ☐ If no please provide below:

Mailing Address: _____

City Province Postal Code

PROJECT SUMMARY

Project Name: _____

Start Date: _____ Grant Requested: \$ _____
(DD/MM/YYYY) (\$5,000 Cdn. Max)

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PROJECT DESCRIPTION/OBJECTIVES

ITEMIZED BUDGET (\$CDN)

Budget

Amount requested (\$5000 CAD max)		\$	
Do other funds exist for this event?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
		If Yes, please complete the following:	
Source:		Amount:	
Source:		Amount:	

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SIGNATURE

- ☐ I certify that the enclosed application for funding from the Immunodeficiency Canada Physician Network represents a project of which I am the Lead Physician. I confirm that I am responsible for the development of the proposal. If funded, I will act as the Lead Physician and will assume responsibility for the implementation and performance of the proposed project.
- ☐ I am aware that if I receive funding, I am responsible to acknowledge Immunodeficiency Canada for funding of this project in any publications, presentations, signage, displays or public acknowledgements.
- ☐ At the conclusion of the project, I assure the completion of a grant report within 3 months. This report can be found at www.immunodeficiency.ca
- ☐ I agree to all of the above terms by signing this application.

Note: *Digital signatures are accepted for emailed applications.*

Signature: _____

Name (Please print): _____

Date: _____

Email completed Grant Application to network@immunodeficiency.ca