

## EDUCATIONAL GRANT APPLICATION FORM

**Instructions:** This application form is for **Educational Grants** and NOT for Investigator-Initiated Study Research Grants, General Research Grants, Charitable Contributions/Donations, or Commercial Sponsorships. An Educational Grant is a payment or in-kind support to a third-party organizer or institution to support a specific medical or scientific educational program or programming (e.g., support for a continuing medical education program, scholarship, or fellowship). Applications must be received at least **ninety (90) days** prior to the event occurring for consideration. Also, please note that your application must be submitted with all required documents (see the "Required Documentation" section of this form). Incomplete applications and/or missing or incomplete required documents will cause delays and may result in a denial of your application.

Applications are accepted throughout the year. Please submit your application by email to:

- [MVGrantCommittee@microvention.com](mailto:MVGrantCommittee@microvention.com)

For any questions, please contact the MicroVention Grant Liaison Manager, Linn Pearce: [linn.pearce@Microvention.com](mailto:linn.pearce@Microvention.com).

### REQUESTING ORGANIZATION INFORMATION

Date: ____/____/____	Name of Organization/Institution: _____
Organization Contact: _____	Title: _____
Address: _____ _____	
City: _____	State/Province: _____
ZIP/Postal Code: _____	Country: _____
Telephone Number: _____	Email Address: _____
Website: _____	
Federal Tax ID Number: _____	Tax Status: _____
Year of Establishment: _____	Organization Type: _____
Annual Operating Budget: _____	
Is the organization (or parent organization) on the United States Centers for Medicare & Medicaid Services (CMS) Open Payments List of Teaching Hospitals (Y/N)? _____	
Do you have a Board of Directors (Y/N)? _____ If yes, please provide a list all Members of the Board of Directors.	
1. Is the requesting organization comprised entirely of, owned by, or controlled by Health Care Professionals ("HCPs") (Y/N)? _____	
2. Is the requesting organization a Health Care Organization ("HCO") or physician's practice (Y/N)? _____	
3. Is a MicroVention employee on the Board of Directors of the requesting organization (Y/N)? _____	
4. Does a MicroVention employee have a controlling position in the requesting organization (Y/N)? _____	
5. Is the requesting organization a customer of MicroVention (e.g., can it purchase, prescribe, or influence the use of any MicroVention products) (Y/N)? _____	
6. Is the requesting organization a government entity (Y/N)? _____	

7. Are any of the requesting organization's owners, officers, directors, or managers (current or former) a Government Official ("GO") or a Family Member of a GO (Y/N)? \_\_\_\_\_
8. Do any of the requesting organization's owners, officers, directors, or managers (current or former) have a business relationship with a GO or a government entity, which has decision-making authority or official influence (Y/N)? \_\_\_\_\_
9. To your knowledge, are there any actual or potential conflicts of interest between the requesting organization and MicroVention (e.g., are any representatives of the requesting organization related to a MicroVention employee) (Y/N)? \_\_\_\_\_
10. Within the past 5 years, has the requesting organization, or any of its owners, officers, directors, employees, or sub-contractors, been the subject of any government investigation or proceeding involving fraud or corruption (e.g., bribery, money laundering, or other corrupt practices) (Y/N)? \_\_\_\_\_

If you answered "Yes" to 9 and/or 10 above, please explain the potential conflict and/or the government investigation/proceeding: \_\_\_\_\_.

**Parent Organization Information**

Is the requesting organization part of a larger organization (Y/N)? \_\_\_\_\_ If yes, please provide the following information:

Parent Organization Legal Name: \_\_\_\_\_

Parent Organization Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent Organization Federal Tax ID Number (for U.S. entities): \_\_\_\_\_

Parent Organization Chapter/Branch/Department: \_\_\_\_\_

**Prior Funding**

Has the requesting organization ever received funding from MicroVention (Y/N)? \_\_\_\_\_ If yes, please provide the following information:

Year when funding was provided: \_\_\_\_\_ Amount of previous funding: \_\_\_\_\_

Type of previous funding: \_\_\_\_\_

**Additional Information**

Has the requesting organization discussed this grant request with any MicroVention employee (Y/N)? \_\_\_\_\_

Has anyone from MicroVention assisted with the preparation of this grant request (Y/N)? \_\_\_\_\_

Has a MicroVention employee promised support for the requesting organization (Y/N)? \_\_\_\_\_

**PROGRAM INFORMATION**

Name of program/initiative for which support is requested:	
Program Description (please also provide a detailed agenda):	
Therapeutic Area:	
Needs Assessment:	

Program Goals:	
Proposed Outcome:	
Methods for Measuring Success:	
Total Amount of Funding Requested:	\$
Total Budget for Program/Initiative	\$
Please indicate how the program will further its educational objectives:	
List other current sources of funding:	

**PROGRAM ACTIVITIES and DELIVERY FORMAT**

Under this section you are required to provide a general description of the activities which are part of the program (i.e., live or web program), including those for which MicroVention’s support is sought, and the delivery format (e.g., live case, didactic session, hands-on workshop, etc.)

Delivery Format Type ( <b>specify if Live or Web</b> ):	
Delivery Format:  <b>If Live:</b> indicate if it is a hands-on workshop, satellite symposia, symposia, research conference, lectures, didactic sessions, live cases  <b>If Web:</b> online education/training module, webcast/live program, or other	
Number of Speakers/Faculty:	
Activity Start and End Date:	
Web URL (optional):	
Geographic Reach (e.g., Local, Regional, National, International) :	
Audience Generation Tactics:	
Audience Group & Anticipated Number of Attendees for Each Group, e.g., Physicians (i.e., Interventional Radiologists, Interventional Cardiologists), Nurses, Technicians, Fellows:	
Specialty:	
Category of Credit (e.g., ACCME, AMA, CAST, N/A, Other):	
CE/CME Credit Hours for Category (Number of credit hours available for this specific activity):	
BUDGET:	<b>Please include the budget as an attachment to this application.</b> The budget for the event shall include, but not be limited to, all costs related to Faculty and Staff, Honoraria, Meals, Meeting Logistics, Content Development, Accreditation Costs, and/or Outcomes.

**ACCREDITATION DETAILED INFORMATION (IF APPLICABLE)**

Is the program accredited?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your organization the accreditor?	<input type="checkbox"/> Yes <b>If yes, please attach a copy of the accreditation certificate.</b>

	<input type="checkbox"/> No <b>If no</b> , provide the Accreditor Organization Name:
By checking this box, the applicant certifies that the program is accredited and the organization will abide to all terms and conditions set forth by the accrediting body.	<input type="checkbox"/>

#### REQUIRED DOCUMENTATION

W-9 Form (current) (or comparable form for applicants outside the United States)	
List of Members of the Requesting Organization's Board of Directors	If applicable
IRS Letter of Determination	If applicable
Accreditation Certificate	If applicable
Detailed Agenda	For live education events, the agenda must include hour by hour detail of all the content to be presented.
Program Budget	
Invitation Flyer/Marketing Material	Optional
Organization Governing Document (e.g., Organization's Articles of Incorporation)	

#### PAYMENT

Is the Payee address the same as the Organization address (Y/N)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If No</b> , please indicate the address for forwarding financial awards (checks):
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#### CERTIFICATIONS

<p><b>Please read the following certifications carefully. You must certify the following before you can submit your request to MicroVention for consideration. By signing this application form, you acknowledge that the following statements are true and correct.</b></p> <p>You certify that you are authorized to submit an application for financial support from MicroVention and provide information in an application on behalf of the requesting organization and any partner organization(s), and you affirm that all responses and information provided in this application are truthful, accurate, and complete.</p> <p>You certify that MicroVention has had no involvement in the creation or development of this project or the completion of this application form.</p> <p>You certify that, if approved, the source of all support from MicroVention must be disclosed in all publications and presentations.</p> <p>You certify that neither this request nor the requested funding is conditioned on, related to, or intended as an inducement or reward for: (a) any pre-existing or future business relationship with MicroVention; or (b) any business or other decision relating to MicroVention or its products (including regulatory approval, coverage and pricing determinations, tenders, or formulary status decisions).</p> <p>You certify that neither you nor your organization's directors, trustees, and/or anyone who will be involved in the project(s) that will be funded by this grant are on the OIG exclusion list or FDA debarment list.</p> <p>Please note, if the grant request is approved, you will be required to sign a contract that includes additional terms and conditions as they relate to the execution of the request consistent with all applicable law and MicroVention policy.</p>
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\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Organization Name

## GLOSSARY OF DEFINED TERMS

<b>Family Member of a Government Official</b>	Any spouse, partner, parent, grandparent, sibling, child, niece, nephew, aunt, uncle, cousin, or any other individual sharing the same household with a Government Official.
<b>Government Entity</b>	Any government-, state-, or public-owned or operated (in whole or in part) department, agency, body, authority, organization, or instrumentality thereof (including public hospitals and public universities).
<b>Government Official (“GO”)</b>	<p>Any individual who works for a government agency, entity, or institution. This includes any individual that is employed by an organization that is government owned or controlled. This also includes associates of global non-profit organizations, which the U.S. Foreign Corrupt Practices Act refers to as “public international organizations,” like the United Nations, the Red Cross, or the World Bank.</p> <p>For clarity, the following individuals are considered Government Officials:</p> <ul style="list-style-type: none"> <li>• Any elected or appointed official (e.g., Minister of Health, elected politician, any member of a royal family);</li> <li>• Any person who works for, or on behalf of, a Government Official, government agency, or an enterprise performing a governmental function (e.g., customs officer, tax authority, police officer, military personnel);</li> <li>• Any person who works for, or on behalf of, a state-owned or controlled entity (e.g., an HCP employed by the Ministry of Health or that works for government-owned hospitals or clinics);</li> <li>• Any political party officer or candidate for public office (e.g., a candidate running for governor or mayor);</li> <li>• Any person acting for, or on behalf of, a public international organization (e.g., the United Nations, the Red Cross, or International Monetary Fund);</li> <li>• Any person who is considered a Government Official under local law; or</li> <li>• Any Family Member of a Government Official, including any spouse, partner, parent, grandparent, sibling, child, niece, nephew, aunt, uncle, cousin, or any other individual sharing the same household with a Government Official.</li> </ul>
<b>Health Care Professional (“HCP”)</b>	Any person or entity (a) authorized or licensed to provide health care services or items to patients or (b) who is involved in the decision to purchase, prescribe, order, or recommend a medical device/technology. This term includes individual clinicians (for example, physicians, nurses, and pharmacists, among others), provider entities (for example, hospitals and ambulatory surgical centers), and administrative personnel at provider entities (for example, hospital purchasing agents). This term does not include Health Care Professionals who are bona fide associates of a Company, while acting in that capacity.
<b>Education Grant</b>	A payment or in-kind support to a third-party organizer, healthcare organization, or institution to support a specific medical or scientific educational program (e.g., continuing medical education, scholarship, or fellowship) dedicated to the advancement of genuine medical education of healthcare professionals (“HCPs”), patients, and/or the public on clinical, scientific, and/or healthcare topics relevant to the therapeutic areas in which MVI is interested and/or involved.
<b>MicroVention (“MVI”)</b>	MicroVention, Inc. and its global affiliates.