

## MoKP CKD Educational Silver Award Application--FY16

Name: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Email : \_\_\_\_\_

Grant Request: \$ \_\_\_\_\_ (not to exceed \$500)

Describe Educational  
program: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Expected project dates: From: \_\_\_\_\_ To: \_\_\_\_\_

What outcomes will be measured to show impact of educational effort?

\_\_\_\_\_

\_\_\_\_\_

Estimated Expenses:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*\_\_\_\_ Yes, I will use these funds to promote CKD Education to Missourians, and provide a summary with outcomes of the CKD Educational project upon completion. Will recognize MoKP as funding sponsor on any publications, posters and educational materials developed.*

Signature: \_\_\_\_\_

Send to: MoKP Director at Fax #573-882-0167 or Email: [peacelj@health.missouri.edu](mailto:peacelj@health.missouri.edu)

MoKP Office Use only:

Date:

Approval amount:

Approval by:

Project summary report due date: