Pharmaceutical Grant Application

Please provide an annual report, if available. If your annual report answers questions below please reference that herein.

ORGANIZATION INFORMATION

1. Name of applicant (address, phone number, fax, email, Skype account, FB page)

_____

2. Name of ministry/ Ministry contact (address, phone number, fax, email, Skype account, FB page) Website (if one exists)

_____

3. Shipping address (not a PO Box) _____
4. Final destination (if not the shipping address above) _____
5. Do you have non-profit status? _____ Include documentation from governing agency.
6. What is your mission statement? _____
7. Are you affiliated with a church or religious organization? If so, please describe _____

_____

8. What year was your organization established? _____

OPERATIONAL INFORMATION

9. History of clinic / hospital. (1 page maximum)
10. Tell us about the community. (1 page maximum)
11. What is your typical patient volume for one week? _____ One month? _____ One year? _____
12. What are the top 5 most frequent clinical diagnoses treated by your medical professionals?

_____

_____

_____

OPERATIONAL INFORMATION (continued)

13. Reason clinic / hospital needs medicine or funding now. (1 page maximum)
14. Additional rationale for supporting the clinic / hospital. (1 page maximum)
15. Proof of local ownership/management. Include copies of licensure for clinic/ hospital.
16. Do you have a permit to import medicine duty free? _____ Include permit issued by the Ministry of Health or Customs.
17. Can you obtain customs preclearance of a shipment of medicine? _____
18. How many full-time prescribers work at the clinic / hospital? _____
19. How many part-time prescribers work at the clinic / hospital? _____

20. Please list the key staff at clinic / hospital including title and education. Attach staff members' licenses.

1._____ 2._____ 3. _____

4._____ 5._____ 6. _____

FINANCIAL INFORMATION

21. Financial oversight and accountability. Please provide information about the clinic's leadership structure. (1 page maximum)
22. Does the clinic / hospital have a Board of Directors? _____
23. Please provide a profile on your Board of Directors including Director's name, background and church affiliation.
24. What measures are in place to insure financial accountability and transparency? _____

_____

25. What is your clinic's / hospital's total income? _____
26. Do you have a regular audit of your books? _____
27. Please provide a copy of the most recent annual financial statements.
28. Please provide a copy of your operational budget for the most recently completed fiscal year.
29. Please provide a copy of your operation budget for the current fiscal year.
30. Sustainability. Please provide information regarding how this clinic / hospital will maintain qualified personnel and financial stability. (1/2 page maximum)
31. What other sources of financial support have you had over the last five years? ___ _____

_____

32. Do you have other sources of funding for medicine? _____

ACCOUNTABILITY INFORMATION

33. Christian commitment. Please tell us about the clinic's / hospital's connections to the local Christian community. What are you doing to meet the spiritual needs of patients? (1/2 page maximum)
34. Safeguarding measures. What measures are in place to oversee the use of the medicine so that they are not stolen or misused? (1/2 page maximum)
35. Please describe your pharmaceutical storage room? (1/2 page maximum)
36. Who has access to your pharmaceutical storage room?
37. References. Please provide two medical references that are neither employees nor Board Members that can evaluate the effectiveness of the medical ministry you provide. Include telephone number and email addresses. *Optional*. Provide a pastoral reference that can endorse the quality of spiritual ministry the clinic / hospital is providing. Include telephone number and email address.

SUPPORT INFORMATION

38. Support requested. Please complete an International Order Form with quantities reasonable to meet your clinic/ hospital needs for the next six months. (These needs should be a reflection of, but not limited to your most commonly treated diagnoses and your patient volume.)
39. Rationale for the requested amount. (1/2 page maximum)
40. If you believe there is any other information, such as photographs, brochures or flyers, that may be beneficial for the committee's consideration to supplement your application, please include it with the completed application.

Please complete and return with all supporting documents via
Email: blessthenations@blessing.org
Fax: Attn: Bless the Nations 918.250.1281
- OR -
Mail: Blessings International
Attn: Bless the Nations
1650 N. Indianwood Avenue
Broken Arrow, OK 74012 USA