

AAP Council on Community Pediatrics
MENTORSHIP AND TECHNICAL ASSISTANCE PROGRAM
Application for Funding

Please type or print legibly

Name: _____ Title: _____
Home Phone: _____ Street Address: _____
Work Phone: _____ City, State: _____
Fax Number: _____ E-mail Address: _____

Please identify in order of preference, 3 possible mentors with whom you would like to work. We encourage you to choose mentors who are pediatricians who are members of the Council on Community Pediatrics. If you would like suggestions for a mentor, please check this box:

Rank	Name	City/State	Requested Expertise
1			
2			
3			

If your mentor already has agreed to participate, please check here .
(Please attach a copy of the mentor's CV.)

Project Name: _____

Project Description (100 words or less):

Please describe the following:

(a) The community pediatrics problem/issue/question to be addressed, or personal skill to be acquired:

(b) The program/organization/community you are hoping to enhance through this project:

(c) Steps already taken to address this issue:

(d) What skills do you hope to develop or outcomes do you hope to achieve through this experience?

Budget detail and justification of line items:

This program will fund travel, meals, and incidental expenses. A typical request would include up to \$1,000 for travel for a 2-day meeting (airfare + hotel [2 nights] + meals [2 days] + ground transportation), and up to \$500 to purchase resources, hold post-meeting conference calls, or conduct other necessary follow-up. A \$500 per day honorarium must be included for the mentor. This should not exceed 2 days.

Expenses will be reimbursed upon completion of the activity.

Budget Item	Description/Formula	\$ Amount
e.g., Honorarium	Mentor Honorarium (1 x \$500)	\$500

Total Grant Requested: _____

Signature of Applicant: _____ **Date:** _____

Please check: Copy of application sent to your AAP Chapter President.

Please send this completed and signed application to:

Council on Community Pediatrics
Mentorship and Technical Assistance Program
American Academy of Pediatrics
Fax: 847/434-8000

For more information about this program, contact:
Regina Shaefer, Manager, Council on Community Pediatrics
800/433-9016, ext 4787

Please do not mark in this box. To be completed by AAP Staff.

Date application received by AAP staff:

Mentor name:

Date approved:

Mentor/Applicant Meeting Date:

Source of Application: New Member Mailing

ListServ Msg

Web

Other _____

