



# NavicentHealthFoundation

Attention: Nena Gilreath  
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Or email to Gilreath.Nena@Navicenthealth.org  
478-633-6189 FAX 478-633-4321

## RESEARCH & EDUCATION AWARDS APPLICATION

(Application must be typed)

**PRIMARY AUTHOR/RESEARCHER:**

Primary Author/Researcher will be the contact person. Provide one name only.

**WORK ADDRESS:**

HOSPITAL BOX: (If Applicable)

WORK TELEPHONE:

FAX NUMBER:

E-MAIL ADDRESS:

TITLE OF RESEARCH PROJECT OR PROPOSAL:

AMOUNT OF GRANT REQUEST: (Not to exceed \$20,000)

ADDITIONAL AUTHORS/RESEARCHERS: (CV's not required.)

(REQUIREMENTS: The Primary or one additional Author/Researcher must be affiliated with Navicent Health)

<i><b>NAME</b></i>	<i><b>ADDRESS</b></i>	<i><b>WORK PHONE</b></i>

DEPARTMENT HEAD: (Chief or Senior Manager)

PRIMARY AUTHOR/RESEARCHER ASSURANCE: I agree to accept responsibility for the supervision, performance, and reporting requirements of this project if an award is made. I have not previously performed or reported on this proposal. I certify that the information contained in this application is true.

\_\_\_\_\_  
SIGNATURE OF PRIMARY AUTHOR/RESEARCHER TITLE

\_\_\_\_\_  
DATE

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**  
**PROJECT TITLE:**

**SCIENTIFIC APPROACH - ABSTRACT/SUMMARY**

Pages 2-4, Weighted 60%

in the space provided, using normal spacing and font size (not less than 11), state the project's goal(s) in concise clear terms, the hypothesis(es) of the project and the primary aims of the proposal. Detailed reference to methodologies and data evaluations should not be included on this page. Include a brief review of previous studies conducted by you and/or others related to your proposal.

**DO NOT EXCEED THIS PAGE**

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**

**PROJECT TITLE:**

**METHODOLOGIES APPROACH**

In the space provided, using normal spacing and font size (not less than 11), explain in one or two pages the specific methodologies to be employed for the collection and interpretation of data used to test the proposed hypothesis(es).

**CONTINUE ON NEXT PAGE IF NECESSARY**

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**  
**PROJECT TITLE:**

**METHODOLOGIES APPROACH CONTINUED:**

**DO NOT EXCEED THIS PAGE**

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**

**PROJECT TITLE:**

**PROJECT APPROPRIATENESS CRITERIA**

Pages 5-6, Weighted 25%

In the space provided, using normal spacing and font size (not less than 11), respond to the following questions which reflect the criteria used to evaluate the appropriateness of proposals for funding.

**What is the significance of this project regarding the improvement of community health?**

**What are the multi-disciplinary and/or interdepartmental characteristics of the project?**

**DO NOT EXCEED THIS PAGE**

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**

**PROJECT TITLE:**

**PROJECT APPROPRIATENESS CRITERIA CONTINUED:**

In the space provided, using normal spacing and font size (not less than 11), respond to the following questions.

**How does this project provide opportunities to enhance educational and/or health provider skills?**

**What is the project's research significance to medical and clinical education?**

**DO NOT EXCEED THIS PAGE**

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**

**PROJECT TITLE:**

**SCIENTIFIC CONTRIBUTIONS AND FUTURE RESEARCH**

Page 7, Weighted 15%

In the space provided, using normal spacing and font size (not less than 11), clearly state the scientific contribution(s) this project is expected to make to the body of research in this field. Future research objectives and opportunities for future funding should be included.

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**  
**PROJECT TITLE:**

**BUDGET FOR PROPOSED PROJECT**

**NOTE: The Research and Education Award does not provide for salaries, travel expense, publication costs or indirect costs.**

CATEGORY	AMOUNT	ITEM(S)	JUSTIFICATION
PATIENT CARE COSTS  COST/PATIENT			
ITEMIZED EQUIPMENT			
ITEMIZED SUPPLIES			
OTHER EXPENSES			
TOTAL			

**Is this project seeking funding from other sources or has funding from additional sources been received? YES NO If yes, identify sources and amounts.**

**ADDITIONAL PAGES MAY BE ATTACHED TO JUSTIFY OR CLARIFY ANY EXPENSES LISTED IN THE BUDGET.**



**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**

**PROJECT TITLE:**

**APPROVAL OF DEPARTMENT HEAD (CHIEF/SENIOR MANAGER):**

I have reviewed the described project with the primary author/sponsor. The project complies with the goals and objectives of the Navicent Health Foundation Research & Education Awards and the goals and objectives of my department. I approve the project and agree to allow the applicant to proceed if an award is made.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE:

**This project does \_\_\_\_\_ does not \_\_\_\_\_ require approval from an institutional review board.**

**This project does \_\_\_\_\_ does not \_\_\_\_\_ require approval from The Institutional Animal Care and Use Committee.**

**If this project does require either approval, attach letters of approval from the appropriate institutional review board.**

**Completed and signed application with all attachments as well as an emailed electronic copy must be submitted to Nena Gilreath at Navicent Health Foundation and [Gilreath.nena@navicenthealth.org](mailto:Gilreath.nena@navicenthealth.org) on or before July 1.**

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:**

**PROJECT TITLE:**

**NAVICENT HEALTH FOUNDATION  
RESEARCH & EDUCATION AWARDS APPLICATION CHECK-LIST**

\_\_\_\_\_ COMPLETED AND SIGNED APPLICATION INCLUDING APPROVAL BY MERCER GRANT'S  
Initial DEPARTMENT IF APPLICABLE

\_\_\_\_\_ IF APPLICABLE, IRB (Institutional Review Board) LETTER OF APPROVAL, ATTACHED YES \_\_\_\_\_ NO \_\_\_\_\_  
Initial

\_\_\_\_\_ IF APPLICABLE, IACUC (Institutional Animal Care and Use Committee) LETTER OF APPROVAL,  
INITIAL ATTACHED YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_ IF IRB LETTER IS NOT ATTACHED, WHAT DATE WAS IT SUBMITTED FOR APPROVAL \_\_\_\_\_  
Initial

\_\_\_\_\_ COMPLETED APPROVAL SHEET  
Initial

\_\_\_\_\_ CURRICULUM VITAE OF PRIMARY AUTHOR/RESEARCHER ONLY  
Initial

\_\_\_\_\_ OR \_\_\_\_\_ PREVIOUS NAVICENT HEALTH FOUNDATION AWARD (Please check one block.)  
Initial YES NO

IF YES, WHAT WAS THE TOTAL AWARD? \_\_\_\_\_

IF YES, IN WHAT YEAR DID YOU RECEIVE THIS AWARD? \_\_\_\_\_

STATUS OF PREVIOUS AWARD

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PRIMARY AUTHOR/RESEARCHER TITLE

\_\_\_\_\_  
DATE:

**FOUNDATION USE ONLY**

DATE APPLICATION RECEIVED: \_\_\_\_\_

PRIMARY REVIEWERS: \_\_\_\_\_

DATE OF COMMITTEE REVIEW: \_\_\_\_\_

COMMITTEE ACTION: DATE \_\_\_\_\_: APPROVED DISAPPROVED APPROVED AMT: \_\_\_\_\_

DATE CANDIDATE NOTIFIED: \_\_\_\_\_ (date letter mailed)

CHECK ISSUED TO: \_\_\_\_\_ DATE \_\_\_\_\_