1. **Organization Requesting Grant** Click here to enter text.**:**
2. **Type of Grant Requested:** Choose an item.
3. **Amount Requesting:** Click here to enter text.
4. **Grant Description:**
* Program Title: Click here to enter text.
* Program Date(s): Start: Click here to enter a date. End: Click here to enter a date.
	+ (This includes conference dates or conference dates for travel scholarship)
* Program Detailed Description: Click here to enter text.
* Program Location: Click here to enter text.
* Detailed Use of funds attached: [ ]  Yes (required for funding consideration)

*\*A copy of the proposed budget must be submitted with this Grant Request*

1. **Educational Program/Congress Information** [ ]  **Not applicable (N/A) – Skip to # 6**
* **Number /Type of attendees expected** (i.e. Interventional Cardiologists, Interventional Radiologists, Angiologists, Vascular Surgeons, etc.): Click here to enter text.
* **Names of other sponsors/potential sponsors**: Click here to enter text.
* **What do we receive in exchange for funding (i.e. recognition on signage, meeting materials, etc.:** Click here to enter text.
* **Presentation type**: Choose an item.
	+ - * If other, specify: Click here to enter text.
* **Accreditation Information** [ ]  **N/A**
	+ Accrediting body name: Click here to enter text.
	+ Number of hours: Click here to enter text.
	+ Category of credit: Click here to enter text.
* **Is an opportunity available for exhibit/advertisement space?** [ ]  **Yes** [ ]  **No**
	+ **If yes, describe type of exhibit or advertisement space and additional cost, if any:** Click here to enter text.
1. **REQUIRED: By checking here, the submitter certifies that Shockwave Medical will not control or influence the program content, selection of faculty, or scholarship recipients.** [ ]
2. **Date Shockwave Medical decision required, if any**: Click here to enter a date.

**If approved, deliver check to:** Click here to enter text.

**Address:** Click here to enter text.

**Employer Identification Number (EIN) or Taxpayer Identification Number (TIN) (*U.S. submissions only*):** Click here to enter text.

**Organization Website**: Click here to enter text. [ ]  **N/A**

 Shockwave Medical contact, if any: Click here to enter text.

**Requestor must submit the following documents with this Grant Request:**

* W-9 Form (Tax ID) *(U.S. submissions only)*
* Program Objectives / Course Agenda
* Detailed proposed budget
* Accreditation statement, including approved hours, when applicable.

*Submission of this Grant Request and documentation does not guarantee approval of the request by Shockwave Medical. Shockwave will only fund grants that the Shockwave Grant Review Committee has approved. Shockwave reserves the right to award less than the amount requested.*

*The undersigned represents and warrants he/she has the authority to submit this request on behalf of the organization requesting the grant, and that this request is unrelated to the purchase of Shockwave Medical product. In addition, the undersigned warrants that Shockwave will have no control over any relevant content, speaker selection, or scholarship recipients, where applicable.*

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

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_