**Requesting Organization Information**

**Organization Name**  Click here to enter text.**:   
  
Organization Address:** Click here to enter text.**:   
  
Organization Contact Email and Phone Number:** Click here to enter text. **Employer Identification Number (EIN) or Taxpayer Identification Number (TIN) (*U.S. submissions only*):** Click here to enter text. **Organization Type:** Choose an item.

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

**Detailed Grant Information**

**Type of Grant:** Choose an item.

* + - * If other, specify: Click here to enter text.

**Amount Requested from Shockwave Medical, Inc.:** Click here to enter text.

**Program/Event:**

* Title: Click here to enter text.
* 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)
* Location: Click here to enter text.
* Detailed Description: Click here to enter text.

**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.
* **Other sponsors/potential sponsors**: Click here to enter text.
* **Will Shockwave Medical, Inc. receive recognition as an educational supporter 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 there 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.

**Date Shockwave Medical, Inc. decision needed**: Click here to enter a date.

**If approved, address where payment should be sent:** Click here to enter text.

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

**REQUIRED: By checking here, the submitter certifies that Shockwave Medical will not control or influence the program content, selection of faculty, or scholarship recipients.**

**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.
* Detailed Use of funds attached:  Yes (required for funding consideration)

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

*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_