



## AMA Foundation Health Care Recovery Fund Grant Application

**Note: Grants will only be made to physicians in active practice who are planning to restore/rebuild their damaged practices within the affected disaster area.**

Physician First Name	Middle Initial	Last Name
Date of Birth	Social Security Number/Taxpayer ID number	
Permanent Residential Address	City/State	Zip Code
Medical Office Address	City/State	Zip Code
E-mail Address (Your e-mail address will not be shared, sold, traded, exchanged or rented.)		
Office phone	Home phone	Cell phone
Area of Medical Practice/Specialty	License number	State
Temporary Address and Telephone Information (if different from permanent information above)		

**The Foundation is a 501(c)(3) organization. All contributions are tax-deductible to the extent permitted by law.**



Identify the disaster to which this application relates and provide briefly details of the physical damage sustained by your medical practice (e.g. damage to office facilities or medical equipment, destruction of records, etc.):

Briefly describe how you would plan to use the grant, if awarded to restore or rebuild your medical practice (e.g., shelter, clothing, equipment replacement, etc.):

What is you anticipated net loss (after insurance recovery) resulting from physical damage to your medical practice described above?

\$ \_\_\_\_\_

Please describe briefly what other disaster relief assistance you have already obtained/are seeking access to for use in restoring or rebuilding your medical practice.

Name of agency providing the assistance/anticipated amount or value of the assistance



Please submit any other information you feel is pertinent to understanding your grant application.

### **Certification by Grant Applicant**

I certify that I have suffered physical damage to my medical practice as described above. I also certify that the other information contained in this application is true and complete. I understand that a material misrepresentation or omission of any information is grounds for denial of a grant. **I understand that the granting of assistance is neither a right nor an entitlement, and that the American Medical Association Foundation shall have sole discretion in determining whether I qualify for or receive a grant.**

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**Signed: Name of Applicant**

**Date:**

**Please print and submit this application by mail or fax to:**

**American Medical Association Foundation**

515 North State Street  
Chicago, IL 60610  
(312) 464-4200 Phone  
(312) 464-4142 Fax

American Medical Association Foundation  
515 N. State Street, 11<sup>th</sup> Floor  
Chicago, Illinois 60610