*Note: FMCRTG will only accept grant requests from US healthcare professionals.*

FMCRTG supports medical organizations and/or institutions involved in strengthening professional knowledge and improving dialysis patient outcomes by providing support for high quality, independent, non-promotional medical and scientific educational programs for healthcare professionals that enable the scientific community to better understand diseases, conditions and treatment strategies.

FMCRTG therapeutic areas of interest for IME grant requests are:

* Mineral and bone disease in CKD patients on dialysis
* Iron deficiency anemia in CKD patients on dialysis
* Fluid Management in CKD patients on dialysis
* Home Therapies
* Critical Care

**To apply for an IME grant, please submit the completed IME Grant Request Form and an electronic copy of each of the following at least 45 days in advance of the scheduled program:**

1. A completed FMCRTG IME Grant Request Form
2. A letter of request (preferably on institutional letterhead) addressed to the FMCRTG IME Grants Review Committee
3. A detailed budget for the program
   * Please include a breakdown of the overall program finances including projected incomes from all sources and expenses.
4. An agenda for the program
   * Please provide sufficient detail to allow evaluation of the appropriateness of the program as a whole, the topics discussed, and speaker(s) involved (where applicable).
   * If the program is still in a planning stage, then a draft agenda is acceptable.
5. An outcome measurement plan for the program
6. A completed, signed IRS W-9 form (taxpayer ID number certification)

**Each of these items must contain sufficient detail for the program to be evaluated by the FMCRTG IME Grant Review Committee. Incomplete applications will not be considered.** Additionally, IME grant requests will be declined based on the following (but not limited to):

* Grant request is outside the scope of FMCRTG therapeutic areas of interest
* Grant request is sponsored by a for-profit educational provider
* Grant request is used to defray the applicant’s ordinary operational expenses or to fund any items that may be considered as gifts or entertainment
* Grant request is used for consulting or other services or goods provided to FMCRTG
* Grant request is used for FMCRTG promotional activities or events
* Grant request is used for programs where any of the speakers are FMCRTG employees
* Grant request is used to improperly compensate a healthcare professional or other person in a position to generate business for FMCRTG or influence the content of the educational program
* Grant request is from a non-US healthcare professional.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Institution/Organization Requesting Grant** |  | | | | | | | | **Date Requested** | |  | |
| **Institution/Organization Secondary Name/Dept:**  **Street Address**  **City, State ZIP** |  | | | | | | | | | | | |
| **Contact Name** |  | | | | | | | | | | | |
| **Contact Telephone Number** |  | **Fax** | | |  | | | | **Email** |  | | |
| **Title of Program** |  | | | | | | | | | | | |
| **Date of Program** |  | **Location of Program** | | | | |  | | | | | |
| **Audience Targeted** |  | **Number of Attendees** | | | | | 100 | | | | | |
| Please list the objectives for the IME program | | | | | | | | | | | | |
| Please provide a needs assessment for the IME program | | | | | | | | | | | | |
| Please select how the program will be delivered: | | | | | | | | | | | | |
| Ground Rounds Series  Internet  Live Educational Series | Stand Alone Conferences  Satellite Broadcast  Teleconference | | | | | Local Medical Education Support  Satellite Symposium  Other | | | | | | |
| **Will this program be accredited?** | Yes No | | | **Please select accreditation provider** | | | | ACCME ACPE  ANCC Other (specify)- CDR, ASWB | | | | |
| **Identify HCPs eligible for continuing education credits** |  | | **Number of continuing education credits offered** | | | | |  | | | | |
| **Will program be evaluated by attendees?** | Yes No | | **Will company supporter have access to program evaluations?** | | | | | Yes No | | | | |
| Please specify how program will be advertised to healthcare community | | | | | | | | | | | | |
| **Are there co-providers for the program?** | Yes No | | | Please list any co-providers and their contact information | | | | | | | | |
| **Total Cost of Program** |  | **Amount of Grant Request** | | | | |  | | | | | |
| **Is additional support being sought for program/research?** | Yes No | Please describe additional financial support | | | | | | | | | | |
| **Is Institution a 501(c)3**  **(non-profit) organization?** | Yes No | I**nstitution’s Tax Identification Number** | | | | |  | | | | | |
| **Disclose any potential conflicts of interest** | . | | | | | | | | | | |