Applied Medical
A New Generation Medical Device Company

Clinical Education Course Request Application: Society Program

Thank you for your interest in requesting support from Applied Medical. Through this interactive form, Applied Medical provides organizations with an opportunity to submit a formal request for support of a clinical education course.

As a new generation medical device company, we believe in making a meaningful difference in healthcare around the world. Accordingly, we are proud to partner with organizations that are equally focused on science and advancing clinical outcomes.

Please submit your request at least 60 days prior to your deadline. Your application will be evaluated by our Grants Committee and a response will be provided within 30 days of your submission.

For more information, please email: ClinicalSupport@appliedmedical.com

Type of Organization

☐ Surgical Society ☐ Non-Profit Organization ☐ Accredited Medical School ☐ Hospital or Medical Center

☐ Other:

Institution/Group Information

Name:

Address Line 1:

Address Line 2:

City: State: Zip: Country:

Website:

Primary Contact

Name: Phone: Email:

Event Information

Activity or Program Name(s):

Event Date(s):

Event Website:

Audience Group (Fellows, Residents, Surgeons, PAs, etc.):

Surgical Specialty:

Accrediting Body:

ACCME Number:

Is this a CME activity? ☐ Yes ☐ No If yes, credit hours:

Will an attendee list be provided at the conclusion of the course? ☐ Yes ☐ No

Will advanced bipolar energy be used in the course? ☐ Yes ☐ No

Event Information (continued)

Registration Deadline: _____

To date, how many registrations do you have for the program? _____

Is there a hotel room block? If yes, name of hotel and room block deadline:

Workshop Information

Number of Workshops/Hands-on Classes/Labs: _____

Number of stations in each Workshop/Hands-on Class/Lab: _____

Number of attendees anticipated at each Workshop/Hands-on Class/Lab: _____

Number of attendees you expect at each station: _____

Based on your past programs, please provide an idea of where participants are coming from (percentage):

_____ Your health system

_____ Surrounding area (regional participants)

_____ United States

_____ International

Shipping Address:

Event Coordinator Contact Information: _____

Name: Phone: Email:

Request Details

Please provide a description of your event and any details about your specific request:

Amount Requested: $

If amount requested is for multiple Classes/Labs please specify:

Grant Name	Amount	Grant Name	Amount

Describe the specific expenses for which the requested funds would be used:

Product Request

In addition to funding, are products/equipment being requested? ☐ Yes ☐ No

Is there an opportunity for us to provide the Voyant Intelligent Energy System (Advanced Bipolar handpieces)? ☐ Yes ☐ No

We often receive equipment/tissue requests in addition to products (examples: lap trainers, laheys, beef tongue, calf colon). Suggestion: If yes, please list the products and equipment being requested. Note quantity and models numbers (if known). A product catalog is available here.

Model #	Description	Quantity (ea)	Model #	Description	Quantity (ea)

Please submit these documents with your application

- W-9
- Letter of Request
- Program Agenda/Curriculum (including objectives, topics and planned speakers)
- Meeting Budget (including complete program expenses)
- Letter of Agreement ☐ If you do not have one, check here and one will be provided.

Please email your completed application to ClinicalSupport@appliedmedical.com.