



Ascension St. Elizabeth Hospital Foundation

Dr. Christopher Wallace Endowment Fund Application

Grant Application Dr. Christopher Wallace Endowment Fund Supporting Mission Work of Affinity Legacy Employees

GUIDELINES:

- All Legacy Affinity physicians, employees, and retired employees with 20 or more years of service are eligible for the corresponding grant opportunity - Wallace Physicians (Affinity Legacy physicians) or Wallace Memorial (other Affinity Legacy employees).
- Must be a medical mission involving direct patient care in a third world country.
- Expenses covered by grant include transportation and lodging for the duration of the mission – separate from any personal time added onto the mission trip.
- Immunization costs can be submitted for consideration.
- Detailed documentation is required for reimbursement of expenses. If receipts detailing room and board within the mission cannot be separated, a letter from the sponsoring organization (on that organization’s letterhead, including address and phone information) confirming payment of these expenses must be provided.
- Cap of \$1,000 for each grant.
- One Wallace Fund Grant can be awarded per person each fiscal year (July 1 – June 30).
- Preference is given to those who have not accessed grant funding previously, followed by consideration of the timing of the last grant awarded (e.g. those funded most recently are awarded last).

Applicant Information

Name/Title: _____

Phone: _____ Email: _____

Department/Location: _____

Home Address: _____

City/State/Zip Code: _____

Have you received Wallace grant funding previously?

____ Yes If Yes, please list the year _____ ____ No

Completed Application can be emailed to: coree.vanthiel@ascension.org, or sent to the foundation office (St. Elizabeth Hospital Foundation, 1506 S. Oneida Street, Appleton, WI 54915)

Please call Coree Van Thiel, grants manager, at 920.223.0643 with questions.

Revised 9/10/19



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Type of Request

____ Wallace Physician Endowment Fund

____ Wallace Memorial Endowment Fund (non-Physician)

Mission Details

Mission Start Date:

Mission End Date:

Location:

Description of Mission:

Budget Information

Registration	\$
Lodging	\$
Airfare/Transportation	\$
Meals	\$
Immunizations	\$
Total Amount:	\$

Signature: _____ Date: _____

Comments:

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