Idaho Arthritis Walk

Request for Funding

Applicant Information

Name _____

Address _____

City, ST Zip Code _____

Phone / Email _____

Request Funds for: _____

_____

Amount Requested: _____

Physician treating Rheumatologic disease: _____
(If physician recommended please submit prescription or letter from physician)

Funds will be paid to the Vendor on your behalf:

Name _____

Address _____

City, ST Zip Code _____

Phone _____

Fax | Email _____

Additional Comments:

_____

_____
Requestor Signature *Date*

NOTE: To be eligible for funding requests you need to be currently treated by a physician for a Rheumatologic disease. This funding is not for medical equipment for medications. Funds are for promotion of community awareness and exercise for the patient only (i.e., gym membership, athletic shoes, exercise equipment, support groups and functions).

Submit form by emailing to idahoarthritiswalk@gmail.com Or mail to Idaho Arthritis Walk – 1200 N Main St #1533, Meridian, Idaho 83680 or complete form on www.Idahoarthritiswalk.com

Approval

☐ Approved ☐ Denied Reason for denial: _____ Date:_____

Approved Amount: _____

Committee members deciding: _____

If denied date requestor notified: _____

If approved date funds sent to vendor: _____