



Date: _____

Education Fund Application Form

Children's Miracle Network will consider funding up to \$1,000 for staff to attend pediatric specific conferences or workshops. The request must be for education that is not a requirement in the applicant's job description. Applicants must be employed by a not-for-profit agency within the 17-county CMN region (Adams, Ashland, Bayfield, Clark, Forest, Gogebic, Iron, Langelade, Lincoln, Marathon, Oneida, Portage, Price, Sawyer, Taylor, Vilas and Wood). Requests for lodging and registration only will be paid on approved requests based on availability of funds and critical need for the training requested. Due to limited funds, CMN is unable to provide funds to the same individual in consecutive years.

Name of Applicant/Traveler: _____ Job Title: _____

This request will benefit the work I do with children at:

Ministry Saint Joseph's Hospital Marshfield Clinic Other _____

Department: _____ Length of Service: _____

Telephone Number(s): _____

Name of Conference: _____

Date(s) of Conference: _____ Location: _____

Who is the target audience of this conference: _____

Have you attended a conference in the past two years? Yes No

If yes, please provide the name of the conference, date(s) attended and how it was financed:

Please describe the content of the conference you are requesting to attend and attach a brochure/conference materials, if available:

Describe the problem/need this conference will address:

How will this request impact the way you care for and treat children?

How will mileage/airfare, meals and other expenses be paid if CMN provides funds for lodging and registration?

Budget

CMN funds can be used for lodging and registration only. Note that CMN funds will not be used for meals, airfare or mileage for staff education.

	Total Needed	CMN Request	Paid by
Lodging	\$ _____	\$ _____	_____
Registration	\$ _____	\$ _____	_____
Airfare	\$ _____	\$ -0- _____	_____
Mileage	\$ _____	\$ -0- _____	_____
Meals	\$ _____	\$ -0- _____	_____
Other	\$ _____	\$ -0- _____	_____
TOTAL	\$ _____	\$ _____	

APPROVED BY:

_____	_____	_____
Department Director/Supervisor's Signature	Title	Date
_____	_____	
Director of Development Children's Services	Date	
_____	_____	
Foundation Director	Date	
_____	_____	
Vice President – Administrative Services	Date	

Return this form to
Children's Miracle Network Hospitals
611 St Joseph Ave
Marshfield Wis 54449