

**Department of Health & Human Resources/Bureau for Public Health
Office of Epidemiology and Prevention Services
BioSense 2.0 Early Adopter Grant Program
Application**

Date of application: _____

Hospital Information

Name of Hospital (legal name)

Address

City, State, Zip

Employer Identification Number (EIN)

Phone

Fax

Website

Name of contact person regarding application

Title

Phone

E-mail

Proposal Information

Please give a 2-3 sentence summary of request:

Population served: _____ Geographic area served: _____

Project dates: _____ Fiscal year end: _____

Budget Summary (from Detailed Line Item Budget)

Equipment Costs _____

Contractual Costs (Consulting Services/Implementation and Upgrade Fees) _____

Other Costs _____

Total Grant Request

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Authorization

I certify that the information contained herein is true and accurate to the best of my knowledge, and I am authorized to submit this application on behalf of the applicant organization listed above.

Signature

Print Name

Title

Date