ALLIANCE HEALTH PROGRAM End of the Year Report

Program Title:
Participating Organization: **Email:**
Address: **Phone:**
Contact Person:
Brief Summary of SCMSA Program/Project:

_____
_____
_____
_____

SCMSA Sponsor: **Email:**
Address: **Phone:**
Role:
Volunteer Name and Duties (Identify SCMSA members):

_____
_____
_____

List in-kind (non cash) contributions from SCMSA members:

Program Goals: **Results:**

_____
_____
_____
_____
_____

Program Expenditures: (Submit Receipts to SCMSA Secretary for Reimbursement)

_____
_____
_____
_____

Recognition of SCMSA's contribution (funds and/or volunteers):

Recommendations/ Comments:

_____
_____
_____
_____
_____

Submitted by: **Date:**

(Send hard copy to Amy Gelber, 1605 Scarlett Place, Springfield, IL 62704 by April 15, 2017 for consideration for 2018 grants)