MUSIC EDUCATION GRANT REQUEST FORM

Today's Date:_____ Event Date:_____

Your Name:_____

School/Association:_____

Address:_____

City, State, Zip:_____

Email Address:_____

Name of the Event:_____

Location of the Event:_____

Time of the Event: _____Approximate Number of Audience:_____

Clinician's Name:_____

Clinician's Instrument:_____

Name of Your Local KHS America Dealer:_____

FINANCIAL INFORMATION

Clinician Fees:_$_____ Clinician Expenses:_$_____

School Contribution:$_____ Dealer Contribution:_$_____

GRANT AMOUNT REQUESTED FROM KHS AMERICA:_____$_____

Please email completed form to: rick.dejonge@khsmusic.com
or you may fax the form to: 615-773-9975

GRANT REQUESTS MUST BE SUBMITTED WITHIN 30 DAYS OF THE EVENT