Reference: _____

EDUCATIONAL GRANT APPLICATION FORM

Instructions: This application form is for **Educational Grants** and NOT for Investigator-Initiated Study Research Grants, General Research Grants, Charitable Contributions/Donations, or Commercial Sponsorships. An Educational Grant is a payment or in-kind support to a third-party organizer, healthcare organization, or institution to support a specific medical or scientific educational program or programming (e.g., continuing medical education program, scholarship, or fellowship) dedicated to the advancement of healthcare professionals ("HCPs"), patients, and/or the public on clinical, scientific, and/or healthcare topics relevant to the therapeutic areas in which MicroVention is interested and/or involved. Applications must be received at least **ninety (90) days** prior to the event occurring for consideration. Also, please note that your application must be submitted with all required documents (see the "Required Documentation" section of this form). **Incomplete applications and/or missing or incomplete required documents will cause delays and may result in a denial of your application.**

Applications are accepted throughout the year. Please submit your application by email to:

EMEA: GrantCommittee.Emea@microvention.com.
All others: MVGrantCommittee@Microvention.com.

For any questions, contact MVGrantCommittee@Microvention.com or GrantCommittee.Emea@microvention.com.

A reference number will be assigned to each application and should be referenced in any interaction related to the application.

REQUESTING ORGANIZATION INFORMATION

Date: _____/_____/_____ Name of Organization/Institution: _____

Organization Contact: _____Title: _____

Address: _____

City: _____ State/Province: _____

ZIP/Postal Code: _____ Country: _____

Telephone Number: _____ Email Address: _____

Website: _____

Federal Tax ID Number (for U.S. entities): _____

Tax Status: _____

Year of Establishment: _____ Organization Type: _____

Annual Operation Budget: _____

Is the organization (or parent organization) on the United States Centers for Medicare & Medicaid Services (CMS) Open Payments List of Teaching Hospitals (for U.S. entities) (Y/N)? _____

Do you have a Board of Directors (Y/N)? _____ If yes, please provide a list all Members of the Board of Directors (names and titles).

1. Is the requesting organization comprised entirely of, owned by, or controlled by Health Care Professionals ("HCPs") (Y/N)? _____

2. Is the requesting organization a Health Care Organization ("HCO") or physician's practice (Y/N)? _____

3. Is a MicroVention employee on the Board of Directors of the requesting organization (Y/N)? _____

4. Does a MicroVention employee have a controlling position in the requesting organization (Y/N)? _____

5. Is the requesting organization a customer of MicroVention (e.g., can it purchase, prescribe, or influence the use of any MicroVention products) (Y/N)? _____

6. Is the requesting organization a government entity (Y/N)? _____

7. Are any of the requesting organization's owners, officers, directors, or managers (current or former) a Government Official ("GO") or a Family Member of a GO (Y/N)? _____

8. Do any of the requesting organization's owners, officers, directors, or managers (current or former) have a business relationship with a GO or a government entity, which has decision-making authority or official influence over MicroVention's business activities (Y/N)? _____

9. To your knowledge, are there any actual or potential conflicts of interest between the requesting organization and MicroVention (e.g., are any representatives of the requesting organization related to a MicroVention employee) (Y/N)? _____

10. Within the past 5 years, has the requesting organization, or any of its owners, officers, directors, employees, or sub-contractors, been the subject of any government investigation or proceeding involving fraud or corruption (e.g., bribery, money laundering, or other corrupt practices) (Y/N)? _____

If you answered "Yes" to 9 and/or 10 above, please explain the potential conflict and/or the government investigation/proceeding: _____.

Parent Organization Information

Is the requesting organization part of a larger organization (Y/N)? _____ If yes, please provide the following information:

Parent Organization Legal Name: _____

Parent Organization Address: _____

City: _____ State: _____ Zip: _____

Parent Organization Federal Tax ID Number (for U.S. entities): _____

Parent Organization Chapter/Branch/Department: _____

Prior Funding

Has the requesting organization ever received funding from MicroVention (Y/N)? _____ If yes, please provide the following information:

Year when funding was provided: _____

Amount of previous funding (indicate currency): _____

Type of previous funding: _____

Additional Information

Has the requesting organization discussed this request with any MicroVention employee (Y/N)? _____

Has anyone from MicroVention assisted with the preparation of this request (Y/N)? _____

Has a MicroVention employee promised support for the requesting organization (Y/N)? _____

PROGRAM INFORMATION

Name of program/initiative for which support is requested:	
Program Description (please also provide a detailed agenda):	
Therapeutic Area:	
Needs Assessment:	
Program Goals:	
Proposed Outcome:	
Methods for Measuring Success:	
Total Amount of Funding Requested: (indicate currency)	
Total Budget for Program/Initiative: (indicate currency)	
Please indicate how the program will further its educational objectives:	
List other current sources of funding:	

PROGRAM ACTIVITIES and DELIVERY FORMAT

Under this section you are required to provide a general description of the activities which are part of the program (*i.e.,* live or web program), including those for which MicroVention's support is sought, and the delivery format (*e.g.,* live case, didactic session, hands-on workshop, etc.)

Delivery Format Type: (Specify if Live or Web)	
Delivery Format: **If Live**: indicate if it is a hands-on workshop, satellite symposia, symposia, research conference, lectures, didactic sessions, live cases **If Web**: online education/training module, webcast/live program, or other	
Number of Speakers/Faculty:	
Activity Start and End Date:	
Web URL (optional):	
Geographic Reach:	
Audience Generation Tactics: *e.g.*, Local, Regional, National, International	

Audience Group & Anticipated Number of Attendees for Each Group: *e.g.*, Physicians (*i.e.,* Interventional Radiologists, Interventional Cardiologists), Nurses, Technicians, Fellows	
Specialty:	
Category of Credit: (*e.g.*, ACCME, AMA, N/A, Other)	
CE/CME Credit Hours for Category: (Number of credit hours available for this specific activity)	
BUDGET: **Please include the budget as an attachment to this application**. The budget for the event shall include, but not be limited to, all costs related to Faculty and Staff, Honoraria, Meals, Meeting Logistics, Content Development, Accreditation Costs, and/or Outcomes.	

ACCREDITATION DETAILED INFORMATION (IF APPLICABLE)

Is the program accredited (Y/N)?	
Is your organization the accreditor? **If yes**, please attach a copy of the accreditation certificate. **If no**, provide the Accreditor Organization Name.	
By checking this box, the applicant certifies that the program is accredited and the organization will abide to all terms and conditions set forth by the accrediting body.	

REQUIRED DOCUMENTATION

W-9 Form (current) (or comparable form for applicants outside the United States)	
List of Members of the Requesting Organization's Board of Directors (names and titles)	If applicable
Request Letter	
IRS Letter of Determination (for U.S. entities)	If applicable
Accreditation Certificate	If applicable
Detailed Agenda	For live education events, the agenda must include hour by hour detail of all the content to be presented.
Program Budget	
Invitation Flyer/Marketing Material	Optional
Organization Governing Document (e.g., Organization's Articles of Incorporation)	

PAYMENT

Is the Payee address the same as the Organization address (Y/N)?	
If No, please indicate the address for forwarding financial awards (checks):	

CERTIFICATIONS

Please read the following certifications carefully. You must certify the following before you can submit your request to MicroVention for consideration. By signing this application form, you acknowledge that the following statements are true and correct.

You certify that you are authorized to submit an application for financial support from MicroVention and provide information in an application on behalf of the requesting organization and any partner organization(s), and you affirm that all responses and information provided in this application are truthful, accurate, and complete.
You certify that MicroVention has had no involvement in the creation or development of this project or the completion of this application form.

You certify that, if approved, the source of all support from MicroVention must be disclosed in all publications and presentations.

You certify that neither this request nor the requested funding is conditioned on, related to, or intended as an inducement or reward for: (a) any pre-existing or future business relationship with MicroVention; or (b) any business or other decision relating to MicroVention or its products (including regulatory approval, coverage and pricing determinations, tenders, or formulary status decisions).

You certify that neither you nor your organization's directors, trustees, and/or anyone who will be involved in the project(s) that will be funded by this grant are on the OIG exclusion list or FDA debarment list.

Please note, if the grant request is approved, you will be required to sign a contract that includes additional terms and conditions as they relate to the execution of the request consistent with all applicable law and MicroVention policy.

_____	_____
Name (Please print)	Title
_____	_____
Authorized Signature	Date
_____	_____
Organization Name	Date

GLOSSARY OF DEFINED TERMS

Close Family Member	Any spouse, partner, parent, grandparent, sibling, child, niece, nephew, aunt, uncle, cousin, or any other individual sharing the same household.
Government	Any department, agency, instrumentality, subdivision, or other body of any national, state, regional, or local government, including hospitals or other health facilities, which are owned or operated by a government, and any regulatory agency and government-controlled business, corporation, company and society.
Government Official ("GO")	• Any officer or employee of any national, regional, local, or other government, or any department or agency of such a government, including any elected or appointed official (e.g., a member of a ministry of health); • Any political party, political party official, or candidate for public office at any level; • Any officer or employee of a company or enterprise owned or controlled by, or performing a function of, a government (includes e.g., any non-U.S. HCP employed by, practicing with, or acting on behalf of, a health care entity or agency owned, controlled, or operated by a government body, such as public hospital, clinic, or state university); • Any officer or employee of a public international organization, such as the World Bank, the World Health Organization ("WHO"), the United Nations, the International Monetary Fund ("IMF"), etc.; • Any member of a royal family or armed services; and Any individual acting in an official capacity for or on behalf of any of the foregoing (whether paid or unpaid), or otherwise categorized as a Government Official under applicable local laws.
Health Care Professional ("HCP")	Any person or entity (a) authorized or licensed to provide health care services or items to patients or (b) who is involved in the decision to purchase, prescribe, order, or recommend a medical device/technology. This term includes individual clinicians (for example, physicians, nurses, and pharmacists, among others), provider entities (for example, hospitals and ambulatory surgical centers), and administrative personnel at provider entities (for example, hospital purchasing agents). This term does not include Health Care Professionals who are bona fide associates of MicroVention.
Education Grant	A payment or in-kind support to a third-party organizer, healthcare organization, or institution to support a specific medical or scientific educational program (e.g., continuing medical education, scholarship, or fellowship) dedicated to the advancement of genuine medical education of healthcare professionals ("HCPs"), patients, and/or the public on clinical, scientific, and/or healthcare topics relevant to the therapeutic areas in which MicroVention is interested and/or involved.
MicroVention	MicroVention, Inc. and any MicroVention, Inc.-subsidiary entities (collectively, the "Company").