TERUMO NEURO

Reference: _____

CHARITABLE CONTRIBUTIONS / DONATIONS APPLICATION FORM

Instructions: This application form is for **Charitable Contributions/Donations** and NOT for Investigator-Initiated Study Research Grants, General Research Grants, Educational Grants, or Commercial Sponsorships. A Charitable Contribution/Donation is a payment or in-kind (e.g., product) support provided to further a charitable purpose, such as indigent care, patient care, or public education that is provided to charitable and/or non-profit entities. Applications must be received in time for the Company to have at least **ninety (90) days** to review the application. 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:

Regional Grant Committee : GrantCommittee.Korea@microvention.com.

For any questions, contact： GrantCommittee.Korea@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 of all Members of the Board of Directors (names and titles).

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

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

2. Is a Terumo Neuro employee on the Board of Directors of the requesting organization (Y/N)? _____

3. Does a Terumo Neuro employee have a controlling position in the requesting organization (Y/N)? ___

4. Is the requesting organization a customer of Terumo Neuro (e.g., can it purchase, prescribe, or influence the use of any Terumo Neuro products) (Y/N)? ___

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

6. 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)? _____

7. 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)? _____

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

9. 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 Terumo Neuro (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 Terumo Neuro employee (Y/N)? _____

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

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

MISSION and REQUEST INFORMATION

Organization's Mission Statement:	
Total Amount of Funding Requested: (indicate currency)	
Please indicate how the requested support furthers the charitable mission and charitable focus:	
List other current sources of funding for the Organization:	
Are you seeking IN-KIND product support from MicroVention for any of the activity described above? (If Yes, a Product Support Form shall be attached to this application form)	
Are you requesting MicroVention to loan a Simulator(s)? (If Yes, please describe)	
Are you requesting a Model(s)? (If Yes, please describe)	
May a clinical specialist be present for Simulator and/or Model support?	

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
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 Terumo Neuro 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 Terumo Neuro 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 Terumo Neuro 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 Terumo Neuro 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 Terumo Neuro 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 request are on the OIG exclusion list or FDA debarment list.

Please note, if the 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 Terumo Neuro policy.

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