

HCO Grant Application Form

This Healthcare Organization (HCO) Grant Application Form can be used by Qualifying HCOs to submit a request for a Grant to support attendance of Healthcare Professionals (HCPs) at a national or international scientific congress to enable HCP education that has a meaningful and positive impact on patient care. Astellas maintains a strict policy of not soliciting grants and does not provide grants for the purpose of inducing or rewarding prescriptions of Astellas products.

All data collected in this form has the sole and exclusive purpose of requesting educational support from Astellas. The data will not be shared with third parties and will only be stored for this specific purpose.

SECTION 1: GRANT REQUESTOR DETAILS

HCO Name:	
Address:	
Email address:	HCO Website URL:
I confirm my organization is: ☐ Government/ Public Hospital Government funded Teaching, Specialist, or General hospital ☐ Private Hospital Please note: Astellas may not support requests from Private Hospitals- depending on region	How many HCPs are employed at your hospital? ☐ <50 ☐ 50 – 100 ☐ 101 – 250 ☐ >251 ☐ – 500 ☐ >500
☐ Medical Society/ Association Nationally recognized with its own professional administration and formal governance structure in place. For example, Royal Colleges, Therapy Area Specific Societies, Institutions, Associations, Faculties and Fellowships with a formal governance structure in place	Please confirm if your Society/ Association: ☐ Has national (or wider) coverage ☐ Has more than 100 active members ☐ Has Secretariat or similar person to oversee its membership/activities ☐ Holds meetings for its members each year ☐ Is not set up for the primary or sole purpose of receiving/ disbursing medical education grants
Please note: Astellas DOES NOT support Health Centre, General Practice/ Private Clinics, Non-nationally recognized and/or HCP Owned/Run Associations and Professional Groups	
I confirm the following about my organization: ☐ My organization nor any of its officers or directors, has NOT been charged with, or convicted of, any matter relating to bribery, corruption, fraud, or money laundering in the past five (5) years. ☐ The funds will go into a central bank account subject to internal audit governance/process applied by the organization in line with local tax requirements. ☐ My organization has capacity to organize and execute the logistical requirements of these requests via our own administrative staff or a third party.	

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Which medical educational topic will this grant cover? <i>(please select only ONE topic which is the most relevant)</i>		
☐ Oncology ☐ Hematology	☐ Nephrology ☐ Urology	☐ Immunology (including transplant) ☐ Women's Health
About Your Organization: (Please include a brief description of your organization and why you believe it is a good candidate for an HCO Grant):		

SECTION 2: EVENT DETAILS

Event Name:	Event Date and Location:
Congress or Event website: <i>(required)</i>	
Agenda/Details of Event: <i>(please provide or attach agenda/details; or insert relevant URL of congress official page)</i>	
Needs Assessment: <i>(please provide details on what educational need or gap does this request support? Does the Medical Activity address an important scientific/medical need? Will the activity advance scientific knowledge or clinical practice?)</i>	Educational Outcomes: <i>(please provide details on How will educational outcomes be measured? How will change in HCP knowledge be measured? How will impact on patient care be measured? How will knowledge be shared?)</i>
Is this event accredited by a recognized accreditation body? ☐ Yes <i>(please provide details of the accredited provider)</i> ☐ No	Conference Vetting System (CVS) – e4ethics:* Has the event received a positive assessment on e4ethics? This is required for Astellas to consider support for an applicable event. Search Events – Ethical MedTech EU ☐ Yes ☐ No ☐ Not Applicable <i>(please explain why)</i>
* This assessment is required for major international meetings taking place in countries within scope of the EFPIA Code and expected to attract a total of at least 500 participants attending from more than 5 countries. Congresses that are entirely virtual, with no in-person delegates, are out of scope.	

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SECTION 3: GRANT REQUEST DETAILS

Grant support required by date:	No. of HCPs to support (max. 10): <i>(unless required by local law, you must NOT disclose names or details of HCPs to Astellas)</i>			
Scope of Support Requested: <i>(please provide a cost breakdown of the items that the grant funding will be put towards)</i>				
☐ Registration Fees: NOTE: For International congresses, Astellas supports funding of registration fees only.				
No. of HCPs <i>(max. of 10)</i>	Registration Fees Details	Cost in Currency of Congress Location	Cost in Local Currency	
	☐ In-person / ☐ Virtual ☐ Member / ☐ Non-Member ☐ Early Bird / ☐ Standard ☐ Others:			
Subtotal 'A'				
☐ Travel and Accommodation: NOTE: Reasonable travel and accommodation may be funded only for HCPs attending domestic congresses / if the location of the International congress is in HCP(s)' residing country.				
Item	No. of HCPs <i>(max. of 10)</i>	Details	Cost in Charged Currency	Cost in Local Currency
Travel		<i>(flight/train fees per HCP)</i>		
	<i>(Provide detail on mode of transport, fare and class of service or how transportation costs were calculated)</i>			
Accommodation		<i>(No. of nights X cost/night per HCP)</i>		
	<i>(Provide name of planned hotel or how accommodation costs were calculated, including star rating)</i>			
Subtotal 'B'				
Description of support requested:				
Total Requested Amount (Subtotal 'A' + Subtotal 'B'): <i>The requested amount will be first analyzed by Astellas. If the grant request is approved, we do not guarantee that the total amount requested here will be fully granted.</i>				(in local currency)
Have you requested support from other sources? <i>(please note that you must not request duplicate funding for the same individuals to attend an event)</i>			☐ Yes <i>(please provide details)</i> ☐ No	
How will this support enhance/ maintain patient care? <i>(Please provide details on what educational need or gap does this request support? How will this proposal fill that need? How will patients be positively impacted by this support)</i>				
Statement of Responsibility: I declare for all legal purposes that the information provided is true and I am responsible for its authenticity and veracity.				
Name:		Date:		
Title:				