



MEDICAL EDUCATION GRANT REQUEST FORM

This Grant Request Form must be completed independently, signed and submitted with the required documentation by the Requestor to Atara Medical Affairs for consideration. Incomplete information will result in review delay. Atara does not solicit, suggest or recommend grant requests. With the exception of requests for proposals authorized by the Atara Grant Review Committee, requests otherwise influenced by Atara Personnel will be rejected. All fields are required.

ATARA BIO (s)-0R-15-13-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100 (re)-RCONT

Organization Name:	
Organization Address:	
Organization Website:	
Contact Name and Title:	
Contact Phone / Fax:	
Contact Email:	

MEDICAL EDUCATION GRANT REQUEST

Amount Requested:		Date Needed:	
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Note: Grant requests must be submitted a minimum of 60 days in advance of program start date.

Has Requestor/Member:

Program Description and Objectives:	
Target Audience:	

Submit completed Medical Education Grant Request Form and required documentation to grantrequests@atarabio.com

Version dated July 23, 2020

	Program Agenda	Needs Assessment
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REQUESTOR PAYMENT INFORMATION

The following information is required to process all payments and may be submitted with this Form or

Atara Grant Review Committee Use Only	
Grant Review Committee Administrator:	
Grant Review Committee Action: Approved at _____ Not Approved	
Signature:	Date: