DIRECTIONS

- **This Medical Education Grant Request Form is REQUIRED to be completed independently by a third party and submitted to Atara Medical Affairs for all requested Medical Education Grant funding requests.**
- **Medical Education Grants may be provided to independent third parties in support of programs that offer educational opportunities for Healthcare Providers on topics related to Atara's research and business objectives in therapeutic areas in which Atara participates or those that are of interest to Atara.**
- **Atara Personnel may not solicit, suggest, or recommend that any individual or entity seek a grant from Atara. Except for requests for proposals distributed or authorized by the Atara Grant Review Committee, funding requests that are solicited by Atara Personnel will be rejected.**

REQUESTOR INFORMATION	
Requesting Organization Name:	
Mailing Address:	
Website:	
Primary Contact's Name & Title:	
Phone:	**Fax:**
Email Address:	
MEDICAL EDUCATION GRANT INFORMATION ***NOTE:*** *All Medical Education Grant requests REQUIRE a description of the proposed program on the requesting organization's letterhead which describes the program and includes the amount of the grant support sought.*	
Date of Event or Activity:	
Name of Event or Activity:	
Description of Event or Activity:	
Location/Address of Event or Activity:	
Projected Attendance:	
Name and Affiliation of Event Speakers (if available):	
Learning Objectives of the Event:	

Event Agenda: *Attach as necessary*

☐ See attachment

Detailed Needs Assessment: *Attach as necessary*

☐ See attachment

Medium through which the Program will be Delivered: *e.g. Live presentation, written materials, online courses, etc.*

Target Audience:

Method to Obtain Learning Results, Outcomes, and other Relevant Program Metrics:

Will CME Credits be Awarded? (Y/N/NA) ☐ Yes ☐ No ☐ N/A	**If Yes, Identity of CE/CME Credits Provider:**

PAYMENT DETAILS

Total Amount Requested:	**Date Needed By:**

Tax ID Number: *Provide signed W-9 and Declaration of Tax-Exempt Status* ☐ W9 Form attached

Complete Itemized Budget: *Total per item program costs including administration, overhead, meals, content development, faculty fees, honoraria, and travel to personnel and HCPs serving as faculty or moderators. Attach budget as necessary.*

☐ See attachment

REQUIRED DOCUMENTATION

NOTE: *Documents listed below must be provided along with this completed form. Requests without any of these required documents will not be accepted or reviewed.*

Document Name	**Attached? (Y/N/NA)**
Description of Proposed Program on Requesting Organization's Letterhead	☐ Yes ☐ No ☐ N/A
W-9 and Declaration of Tax-Exempt Status	☐ Yes ☐ No ☐ N/A
Detailed Program Budget	☐ Yes ☐ No ☐ N/A

INTERNAL ATARA BIO USE ONLY
REVIEWED & APPROVED BY

Grant Review Committee Administrator Name:

Grant Review Committee Action: ☐ Approved ☐ Not approved

Signature:____

Date: ____