

Please return this form within 15 days of the program completion date by e-mail or fax.

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Recipient Information

Organization _____ Contact Person _____
 Phone _____ Fax _____ Website _____
 E-mail address _____
 Program or project title _____ Program date _____

Program Outcomes

How many people were impacted by or participated in the program or project? _____

Health areas addressed in project (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Access to primary medical care | <input type="checkbox"/> Access to specialty/subspecialty care |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease/stroke |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Teen pregnancy prevention | <input type="checkbox"/> Vision exams (children) |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |
- | | |
|---|---|
| <input type="checkbox"/> Dental care (children) | <input type="checkbox"/> Dental care (adults) |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Infant mortality |
| <input type="checkbox"/> Physical activity/exercise | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Vision exams (adults) | <input type="checkbox"/> Other _____ |

Racial/Ethnic groups served during this project (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Other _____ | | |

Gender of participants impacted by the project: Male Female

Age groups of participants impacted by the project (complete the age range):

- | | |
|--|---|
| <input type="checkbox"/> Prenatal (_____ to _____) | <input type="checkbox"/> Adolescents (_____ to _____) |
| <input type="checkbox"/> Infants (_____ to _____) | <input type="checkbox"/> Adults (_____ to _____) |
| <input type="checkbox"/> Children (_____ to _____) | <input type="checkbox"/> Elderly (_____ to _____) |

The goals of the project/program were met to your satisfaction: Agree Disagree Neutral

If the requested financial donation or sponsorship was not used in its entirety, please explain how the remaining funding will be utilized.

How was Select Health recognized as a donor or sponsor? Please attach printed materials or include website links, if applicable.

Please provide any additional information relevant to your organizational outcomes and Select Health outcomes.