



APPLICATION

Personal Information

Please Print Date of Application _____

First Name _____ Last Name _____

Title _____

Employer _____

Home Address _____

City _____ State/Prov _____

Zip/Postal _____ Country _____

Phone _____ Fax _____

Mobile _____ Email Address _____

Current Member of: IFDH Individual Member and/or member of:
 IFDH Country Member _____
Your Membership # _____

Your Program Description

Brief description of program to be provided: _____

Target Group _____

Number of Children Anticipated _____: Grant Amount Requested (up to \$250): \$ _____

Type of Education Program _____

Additional Preventive Services _____

Approximate Time Frame (*must start at least 4 weeks after submission to IFDH*):
From _____ to _____; # of Weeks _____

List of supplies to be used: _____

Follow-up program: From _____ to _____

Scan and Email this application to: director@IFDH.org

Please allow 4 weeks for review by committee.

Co-Sponsors:



Premier

The International Federation of Dental Hygienists

100 South Washington Street, Rockville MD 20850, USA

● Phone: 240-778-6790 ● Fax: 240-778-6112 ● Website: www.ifdh.org