

# Medical Grant Request Form

Email: [medgrants@retrophin.com](mailto:medgrants@retrophin.com)

RETROPHIN, INC.

Retrophin Sponsor (if applicable)			
<b>Retrophin Contact:</b>			
	<i>Last</i>	<i>First</i>	
<b>Location:</b>	<b>United States</b>		
	<i>Country</i>		
<b>Phone:</b>		<b>E-mail Address:</b>	
Grantee (Requestor) Information			
<b>Name of Institution or Organization:</b>			
<b>Tax ID#</b>			
<b>Address:</b>			
<b>Contact Name:</b>		<b>E-mail Address:</b>	
<b>Phone:</b>		<b>Other Phone:</b>	
Grant Information			
<b>Grant Title:</b>		<b>Is This an Amendment to an Approved Grant?</b>	<b>Yes   No</b>
		<b>Grant Submission Date (MM/DD/YYYY)</b>	
<b>Description of the Grant:</b>	<p>Please provide a reasonably detailed description of the program or activity for which funding is requested; including need, general subject matter, reason for the request, objectives, instructional methods, evaluation plan, detailed program budget, and Requestor's qualifications.</p>		
<b>Institutional Affiliation(s) for CME/CE Accreditation:</b>			
<b>Anticipated Invitees or Audience:</b>			

<b>Amount Requested:</b>		<b>Date/Location of Program:</b>
--------------------------	--	----------------------------------

<b>Grant Status – Grant Committee Use</b>		
<input type="checkbox"/> <b>Approved</b>		<input type="checkbox"/> <b>Not Approved</b>
	<b>EU</b>	<b>US</b>
<b>Medical Affairs Director</b>		
<b>Medical Education Grants Chair</b>		
<b>Legal/ Compliance</b>		
<b>Finance</b>		
<b>Budgeted:</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		
<b>Cost Center:</b>		
<b>Comments</b>		

Grant Request Form – May 29, 2020