See, Test & Treat Grant Reconciliation Form

Please submit this form and supporting documentation within 30 days of your See, Test & Treat event in order to receive the second half of your funding. Note that any funds not utilized must be returned to the CAP Foundation.

1. Contact Information

   Name of CAP Member (Pathologist Lead) for this program _____

   Name of person filling out this form _____

   Phone Number _____

   Email Address _____

2. See, Test & Treat Program location

   Institution Name _____

3. Date of See, Test & Treat program

   Program Date _____ (MM/DD/YYYY)

4. Choose your CAP Foundation Program Manager

   Ranjana Paintal   Julia Rankenburg

5. Medical Equipment

   Expenses to Report?   ☐ Yes
                           ☐ No

   Amount Budgeted _____

   Actual Expenditures _____

   Comments _____

6. Exam, Laboratory and Testing Supplies

   Expenses to Report?   ☐ Yes
                           ☐ No

   Amount Budgeted _____

   Actual Expenditures _____

   Comments _____

7. Temporary Program Cooridinator

   Expenses to Report?   ☐ Yes
                           ☐ No

   Amount Budgeted _____

   Actual Expenditures _____

Comments   _____

8. Support Personal

    Expenses to Report?   ☐ Yes
                              ☐ No

    Amount Budgeted   _____

    Actual Expenditures   _____

    Comments   _____

9. Marketing/Promotion

    Expenses to Report?   ☐ Yes
                                ☐ No

    Amount Budgeted   _____

    Actual Expenditures   _____

    Comments   _____

10. Translation Services

    Expenses to Report?   ☐ Yes
                                ☐ No

    Amount Budgeted   _____

    Actual Expenditures   _____

    Comments   _____

11. Transportation

    Expenses to Report?   ☐ Yes
                                ☐ No

    Amount Budgeted   _____

    Actual Expenditures   _____

    Comments   _____

12. Children's Activities

    Expenses to Report?   ☐ Yes
                                ☐ No

    Amount Budgeted   _____

    Actual Expenditures   _____

    Comments   _____

13. Meals

    Expenses to Report?   ☐ Yes
                                ☐ No

    Amount Budgeted   _____

    Actual Expenditures   _____

    Comments   _____

14. Other

Expenses to Report?   ☐ Yes
                       ☐ No

Amount Budgeted   _____

Actual Expenditures   _____

Comments   _____

15 Total Amounts   _____

Amount Budgeted Total

Actual Expenditures Total   _____

Comments   _____

16. In-Kind Donations/Other Funding Resources   Please summarize any additional funding/donations received in support of your See, Test & Treat event. You may list any in-kind donations that your institution provided for this program as well.

Donor Name	Amt Given/Items Donated	Potential Future Donor
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No
_____	_____	• Yes • No