



## California Medical Association Alliance Grant Application Cover Sheet

**Name of Alliance (State or County)**

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**Non-Profit Tax I.D.#**

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**Contact Person**

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**Address**

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**City/ST/Zip**

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**Contact Phone**

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**Email**

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**Project Title**

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**Amount Requested**

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**Date Submitted**

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Telephone: 209-951-3945 Email: [alliance@cmaalliancenet.org](mailto:alliance@cmaalliancenet.org)  
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