Nurse Support Program II FY 2027
Competitive Institutional Grants Cover Sheet

Lead Applicant Institution/Organization: _____

Project Title: _____

Partnership Members: _____

_____

Project Duration: _____

Funding Requested: _____ Value of Match (Funds, In-Kind, etc.): _____

Type of Grant:

- ☐ Planning
- ☐ Implementation
- ☐ Continuation
- ☐ Resource Grant (if applicable, check below)
  - ☐ P.D. Resource Grant
  - ☐ S.S. Resource Grant

Type of Competitive Grant Initiative (CHOOSE ONLY ONE)**:**

- ☐ Initiative to Increase Nursing Pre-Licensure Enrollments and Graduates
- ☐ Initiative to Advance the Education of Students and RNs to BSN, MSN, and Doctoral Level
- ☐ Initiative to Increase the Number of Doctoral-Prepared Nursing Faculty
- ☐ Initiative to Build Collaborations between Education and Practice
- ☐ Initiative to Increase Capacity Statewide
- ☐ Initiative to Increase Cohen Scholars as Future Faculty and Clinical Educators
- ☐ Initiative to Increase Education That Advances Practice In Community Health Settings/ Advances Population Health

Projected Outcomes:
(Identify below the number of additional outcomes expected from funding)

Final Outcomes	Projected Increase (# of Additional)	Describe Degrees/Results
Nursing Pre-Licensure Graduates		
Nursing Higher Degrees Completed		
Nursing Faculty at Doctoral Level		
Collaborative, Statewide or Community/Population Health Results		

Project Director

Project Director's Name: _____

Title: _____

Mailing Address: _____

Phone: _____ E-Mail Address: _____

Signature: _____

Grants Office

Grants Office Contact Name: _____

Title: _____

Mailing Address: _____

Phone: _____ E-Mail Address: _____

Signature: _____

Finance Office

Finance Office Contact Name: _____

Title: _____

Mailing Address: _____

Phone: _____ E-Mail Address: _____

Signature: _____

Authorized Institutional Representative

Authorized Institutional Representative's Name: _____

Title (President, Vice President, or Dean/Director of Nursing): _____

I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I further certify that if grant funds are awarded, this institution accepts the obligation to comply with terms and conditions set by the Health Services Cost Review Commission and the Maryland Higher Education Commission.

_____ _____

Authorized Institutional Representative's Signature Date