



Request for Grant Change

Project Title: _____

Organization: _____

Contact Person: _____

Email: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip (include +4): _____

No cost extension. Change in ending date only. (Attach explanation.)
Request ending date be extended from _____ to _____

Budget change. (Attach budget change form and justification.)

Personnel change. (Attach curriculum vitae of proposed new personnel and an explanation for the change.)

New (proposed) personnel _____

Position to be changed _____

Present personnel _____

Other: Explanation for request: _____

Required Signatures

Program Director

Signature: _____ Date: _____

Name: _____ Title: _____

Approving Institution Official Signature

Signature: _____ Date: _____

Name: _____ Title: _____ Director of _____

Komen Approved by: _____
Printed Name: _____ Date: _____

Request for Change of Grant Budget

	Original Budget	New Budget (Proposed)
Salaries		
Fringe (Benefits and Payroll Taxes)		
Consultant Costs		
Supplies		
Equipment (not to exceed 30% of direct costs)		
Travel		
Patient Care Costs		
Screening Mammography, Ultra Sound, (Adding Ultrasound guided bx and MRI of the breast.)Breast surgeon Consultations.		
Treatment		
Sub-Contracts		
Other (itemized Below)		

Subtotal - Direct Costs		
Indirect Costs (not to exceed 15% of direct costs)		
Total		