



Midwest City Memorial Hospital Authority
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Community Improvement Grant Program

FISCAL YEAR 2025-26 GRANT OUTCOME REPORT

Date: _____

Applicant Name: _____

Address: _____

Phone: _____ Email: _____

Grant Project Title: _____

Grant Money Awarded: \$ _____ Date of any extensions: _____

Please respond **reflectively** to the following questions related to your grant project:

- Has the project objectives as described in your application been achieved (If no, please explain)? Yes No

- Briefly describe the outcomes/accomplishments of this grant project. _____

- Please report any observations, unexpected outcomes or anecdotal information that resulted from the grant project (e.g. news coverage, community event, photos, etc.). _____

- Please provide feedback regarding your overall grant process experience (e.g. working with Hospital Authority staff/application submission process, etc.) _____

Grant Recipient Signature

Grant Recipient Name (Printed/Typed)