



P.O. Box 7338, Madison, WI 53707-7338 \ 45 Nob Hill Road, Madison, WI 53713-7338 \ PHONE 608.276.4000 \ 800.279.4000 \ FAX 608.276.9119

STAFF WELLNESS GRANT PROPOSED ACTIVITY SHEET/SUMMARY FORM

DISTRICT NAME: _____

Number of WEA Trust health assessment participants _____ x \$10 = _____ (total eligible grant dollars)

TOP THREE HEALTH RISKS

1. _____	2. _____	3. _____
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Proposed Activity*	Explain how the grant dollars will be used to support this activity	District Health Risk(s) Addressed	Length of Activity (i.e., 1 hour, 1 day, 30 days, 6 weeks, yearlong)	Estimated Cost	For use as activities are completed**	
					Actual Cost	Actual # of Participants
TOTAL COST:						

* Your WEA Trust health educator must approve all activity/program changes prior to the beginning of the activity/program.

Please make additional copies if more space is required to list additional activities.

****Please submit this completed page as your Grant Summary Form along with your receipts by June 30, 2010.**



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