HEAL Foundation
iPad Application 2017

Date Submitted _____

School Name _____
Address _____
City, State, Zip _____
Teacher Name _____
Tax ID Number or SSN _____
(*This is required by the IRS.*)

School Principal___ _____
Phone _____
Fax _____
Email _____
Website _____

Have you or your organization ever participated in HEAL's First Coast Zoo Walk? ____ Yes ____ No

Do you already have an iPad in your classroom? ____ If yes, how many? _____

How many individuals with Autism are in your classroom? What is the total number of students in your class? Are any non-verbal?

_____

_____

How many Autism classrooms are at your school?

_____

What experience do you have in teaching students with iPads/tablets? What are your goals for your students?

_____

_____

_____

_____

How will your school recognize HEAL as a contributor ie; advertising including HEAL in the name, press releases etc. should your iPad be awarded?

_____

_____

_____

Please initial each line indicating your agreement:

_____ I agree that the iPad cannot be sold, given away, or used for any other purpose then to benefit individuals with Autism in the classroom.

_____ I agree to submit a report on the use of the iPad to the HEAL Foundation.

_____ I agree to leave the iPad in the classroom if I were to leave my job.

_____ If the iPad is not used for its intended purpose, I agree to return it to the HEAL Foundation.

All Grants should be submitted via mail to: The HEAL Foundation
PO Box 140
Ponte Vedra Beach, FL 32004

Signature of Teacher / Applicant_____ **Principal's Signature**_____