2493 4th Avenue West, Suite G | Dickinson ND 58601 | 701.483.2801 | wwww.visionwestnd.com

ENDORSEMENT REQUEST

Date of Request_____

Point of Contact: _____

Organization: _____

Address: _____

Telephone: _____

E-mail: _____

Website: _____

Service(s) Provided (please provide a brief description of the services your organization provides):

Reason for requesting endorsement (if your intent is to establish a relationship with the Consortium for purposes of obtaining grant funding, please include information on the awarding agency and the role you are assigning to VWND):

FOR OFFICE USE ONLY

Date of endorsement received_____

Approval Decision_____ Date of Committee Decision_____

Decision letter sent _____

Notes: _____

_____

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