



**SOCIETY FOR THE ADVANCEMENT
OF BLOOD MANAGEMENT®**
Program and Services Concept Form

Name: _____

Committee: _____

Program/Services Title: _____

Concept Description (1 to 2 paragraphs):

Resources Required: (choose one for each item)

- √ Financial [less than \$10K, \$10K to \$50K, \$50K to \$100K, over \$100K]
- √ Volunteer Time [low, medium, high]
- √ Staff Time [low, medium, high]

What need(s) will be addressed:

What goal(s) and objective(s) of the Strategic Plan will be met:

Program/Services Title: _____

Expected outcome(s):

Estimated Time Line: (choose one)

[less than 6 months, 6 to 12, over 12]

Target Audience:

Potential Partners:

Potential Sponsors, Grants, Foundations: