

SOUTH CAROLINA COUNCIL

OF TEACHERS OF

MATHEMATICS

SCCTM GRANT APPLICATION

Name: _____ SS #: _____
Address: _____
Home Phone: _____ SCCTM Membership Number: _____
School: _____ School Phone: _____
School Address: _____ District: _____
E-mail: _____

Amount Requested: _____
Title of Project: _____ Grade(s): _____
Concise Description of Proposed Project: _____

Supervisor's and Superintendent's Approval:
I support the implementation of the proposed project.

_____	_____
Date	Supervisor's Signature and Title
_____	_____
Date	Superintendent's Signature

By signing below, I agree to the eight conditions of eligibility for the SCCTM Grant.

Date _____ Applicant's Signature _____