SYMMETRY SURGICAL, INC.
Application for Assistance

Symmetry Surgical supports a variety of charitable causes that provide assistance to those in need. We receive a number of requests for donations and review one separately to evaluate the relative merits of each.

Symmetry Surgical will determine the amount of assistance provided to each applicant based on several factors, including but not limited to; the needs of the applicant, the relative needs of others who have applied for assistance, available resources, whether there is other assistance available to cover all or part of the request and any other factors the Company deems important.

After the application is completed and signed, please submit it, along with any additional Information supporting the application, via one of the following methods:

E-mail to: grantsanddonations@symmetrysurgical.com

Or Fax: 1-800-342-3272
Cover page to indicate "Attention Symmetry Surgical Inc. Donations"

Please retain a copy of your application for your own records.

Symmetry Surgical strives to process all applications as quickly as possible. If you have not received a communication within three (3) business days from the date the application was submitted, please call 1-800-251-3000 to inquire about the status of your application.

APPLICANT'S INFORMATION

1. Applicant's Name: _____
2. Applicant's Address: _____
   (street number and name)

   _____
   (city) (state) (zip)

   _____
3. Applicant's 501c status and EIN: _____
4. Applicant's Parent/Corporate Affiliates: _____

   _____

   _____.

3034 Owen Drive, Antioch, TN 37013
Office 800.251.3000
Fax 615.964.5567
symmetrysurgical.com

5. Do any of Applicant or its Parent or Corporate Affiliates do business with Symmetry Surgical? If yes, please describe relationship, amount of purchases in prior year: _____
_____.

6. Applicant's Contact Information:

   a. Contact Name: _____

   b. Contact Phone: _____

   c. Contact E-mail: _____

SUMMARY OF REQUEST FOR NEED

1. Briefly summarize the items, service or other assistance or donation being requested. _____

   _____.

2. Please describe the basis for the need for assistance (if you need additional space, please attach additional pages): _____

   _____

   _____

3. How would the donation received from Symmetry Surgical be used if your application is approved? (If you need additional space, please attach additional pages):

   _____

   _____
   _____

FINANCIAL INFORMATION

1. Does your organization receive income from any other sources?
   Yes __ No __

If yes, please list the source(s) and the amount(s) below:

Source(s)	Amount(s)
_____	$_____
_____	$_____
_____	$_____

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2. Has the organization previously requested assistance from Symmetry Surgical?

   Yes ___ No___

If yes, when and describe circumstances:_____
_____
_____
_____

By signing below you hereby certify that all of the information in this application is true and correct to the best of your knowledge and you agree to the rules and regulations set forth in this application.

Print Name:_____

Signature:_____

Date:_____

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