APPLICATION FORM

Applicant's Information:

___________________________________	___________________________________
Name	Position
___________________________________	___________________________________
Worksite	Department
___________________________________	___________________________________
Phone	E-mail

Project/Equipment Information:

Name of project/equipment:

Purpose of project/equipment:

Why is the funding required? What does the request solve or provide that was not previously available?

Will this impact a specific group of patients? If so, what are their social determinants of health?

What are the timelines? When are the funds required?

What is the impact if funded? Both to staff and to patients? How many patients will be impacted?

Which of the 9 Dimensions of Care does this project/equipment address?

- ☐ Dignity & Respect
- ☐ Effective Treatment Delivery
- ☐ Quality & Safety
- ☐ Information Sharing
- ☐ Participation
- ☐ Collaboration
- ☐ Continuity
- ☐ Spiritual and Cultural
- ☐ Care for the Caregiver

What are the costs associated with the project/equipment? Please provide a detailed breakdown.
Please ensure all costs and quotes are included in this. Note if items are in CDN or US currency below.

Item Description	Amount
Taxes:	
Shipping or Additional Fees:	
TOTAL COST:	

If funded, how will the project/equipment be implemented?

Who will be responsible for reporting back to the KGH Foundation regarding impact?

What else should we know to help us make our decision?

Signatures:

____________________________	____________________________	____________________________
Applicant’s Name	Applicant’s Signature	Date
____________________________	____________________________	____________________________
Cost Centre Manager’s Name	Manager’s Signature	Date