Grant Request Number

UHKF Grant Application Form

1. Identification:

Program/Department:		Hospital	Date: (ddmmyyyy)	
Requested by:		Cost Centre: ______________	Phone #:	
Email Address:				

2. Program Type

Staff / Physician Comfort	☐	Capital Equipment	☐	Education	☐	Innovation	☐
Patient Care / Comfort	☐	Capital Building	☐	Research	☐	Other	☐

3. A) Description Of Item/Service Required (Select Applicable Section)

Grant Request		**Cost**
Details		
Other		Incremental Operating Cost

3. B) Capital Items Details:

Item Request		**Capital Cost**
Function:		Incremental Operating Cost

4. Funding: Please provide foundation fund account name, project ID, and current available fund balance.

UHKF Foundation fund name account #	**Current Available Fund**

5. Impact of Funding: Provide benefits to patient safety or patient care (qualitative & quantitative).

6. Operating Budget Impact: Please describe how incremental operating costs identified above will be accommodated in program/department operating budget?

7. Hospital Approval Support for Funding Request (if approval not required, use N/A) (Email approvals must be included as an attachment):

Operations/Administrative Director:	Date:
Medical Leadership:	Date:
Program/Department VP:	Date:
Information Management:	Date:
Clinical Engineering:	Date:
Maintenance:	Date:
Hospital Finance:	Date:

8. UHKF Approval

Grant Coordinator:	Date:
President & CEO:	Date:
UHKF Board Approval:	Date:

Note: If your explanations go beyond the provided response box limits, please attach additional paperwork with your full responses upon submission.