Immunodeficiency Canada
Immunodéficience Canada

Patient Event Grant Application

SITE INFORMATION

Institution: _____ Department: _____

Address: _____
Street Address

_____
City *Province* *Postal Code*

Contact Social Worker/Nurse/Physician: _____

Phone: _____ Fax: _____

Mobile: _____ E-mail: _____

EVENT SUMMARY

Event Name: _____ Number of participants (proposed): _____

Event Date: _____ Event Location: _____
(*DD/MM/YYYY*)

EVENT DESCRIPTION/OBJECTIVES

ITEMIZED BUDGET ($CDN)

SIGNATURE

☐ If funded, I will act as the Lead and be responsible for the implementation and performance of the proposed Event.

☐ If I receive funding, I am responsible to acknowledge Immunodeficiency Canada for funding of this Event.

☐ At the conclusion of the Event, I assure the completion of a report within 3 months. This report can be found at www.immunodeficiency.ca

Signature: _____

Name (Please print): _____ Date: _____

Email completed Grant Application to contactus@immunodeficiency.ca