 Patient Event Grant Application

#  SITE INFORMATION

Institution:

Address:

*Department*

*Street Address*

*City Province Postal Code*

Contact Social Worker/Nurse/Physician:

Phone: E-mail:

#  EVENT SUMMARY

|  |  |
| --- | --- |
| Event Name:  | Number of participants (proposed):  |

|  |  |
| --- | --- |
| Event Date:  | Event Location: |
| (*DD/MM/YYYY)* |

|  |  |  |
| --- | --- | --- |
|  | **EVENT DESCRIPTION/OBJECTIVES** |  |
|  |
|  **ITEMIZED BUDGET ($CDN)** |
|  |
| **Budget** |
| Amount requested ($5000 CAD max) | $  |
| Do other funds exist for this event? | YES [ ]  | NO [ ]  | If Yes, please complete the following: |
| Source: |  | Amount: |  |
| Source: |  | Amount: |  |

|  |  |
| --- | --- |
| **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](http://www.immunodeficiency.ca/)

Signature: |
| Name (Please print):**Email** |  Date: |  |
| **completed Grant Application to** **contactus@immunodeficiency.ca** |