 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**](mailto:contactus@immunodeficiency.ca) | |