CLATTERBRIDGE HOSPITALS LEAGUE of FRIENDS

APPLICATION FOR GRANT

DEPARTMENT……

EQUIPMENT REQUESTED……

PURPOSE……
……
……
……

COST……DATE REQUIRED……

PLEASE OUTLINE PATIENT BENEFITS ……
……
……
……
……

NUMBER OF PATIENTS TO BENEFIT …….. per annum

NAME OF PERSON SUBMITTING THIS APPLICATION……

COMMENTS OF CLINICAL MANAGER/DEPARTMENT HEAD……

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……
……
……

SIGNATURE APPLICANT…… DATE……

SIGNATURE HEAD OF DEPT…… DATE……

CONTACT DETAILS

EMAIL…… PHONE……

PLEASE ATTACH ANY FURTHER RELEVANT INFORMATION ON A SEPARATE SHEET AND A COST ESTIMATE

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DATE CONSIDERED BY LEAGUE COMMITTEE

NUMBER

APPROVAL DEFERRED REJECTED

COST CHAIRMAN