

## HOSPITAL GRANT REQUEST

- Name of person (employee) making request: \_\_\_\_\_
- Department/Program: \_\_\_\_\_
- Intent of funds: \_\_\_\_\_
- Amount of request: \_\_\_\_\_
- What % of total program cost is this request: \_\_\_\_\_
- Describe the use of the requested funds: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Will request cover salaries? YES \_\_\_\_\_ NO \_\_\_\_\_
- If yes, how much? \_\_\_\_\_
- Has alternate hospital funding been sought? YES \_\_\_\_\_ NO \_\_\_\_\_
- If so, with whom? \_\_\_\_\_
- If denied, why? \_\_\_\_\_
- Would you anticipate making subsequent requests from this Foundation for this program/project/equipment?  
YES \_\_\_\_\_ (Subsequent requests likely)      NO \_\_\_\_\_ (One-time request)
- Further information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**TO BE COMPLETED BY EMPLOYEE'S IMMEDIATE SUPERVISOR**

- **Name of Employee's Supervisor:** \_\_\_\_\_  
(Person completing this section)
- **Reason why this request was not approved by you as a hospital endeavor:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- **Does this request meet the Foundation's criteria of:**  
**A. It is a request that will not be funded through the hospital: YES \_\_\_ NO \_\_\_**  
**B. This will be the only request for funding? YES \_\_\_ NO \_\_\_**  
**Comments if necessary:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DEPARTMENT HEAD APPROVAL:**

\_\_\_\_\_ **DATE** \_\_\_\_\_

**ADMINISTRATIVE APPROVAL:**

\_\_\_\_\_ **DATE** \_\_\_\_\_

**DISPOSITION OF REQUEST:**

\_\_\_\_\_ **Presented to Hospital Board of Directors on (date)** \_\_\_\_\_

\_\_\_\_\_ **Sent to Foundation Office on (date)** \_\_\_\_\_

\_\_\_\_\_ **Presented to Foundation Board of Directors on (date)** \_\_\_\_\_

\_\_\_\_\_ **Approved on (date)** \_\_\_\_\_

\_\_\_\_\_ **Denied on (date)** \_\_\_\_\_

\_\_\_\_\_ **Decision communicated to person submitting request on** \_\_\_\_\_

**One copy to person requesting/One copy to supervisor/One copy to Foundation**