|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date:** |  | | **Total Amount Requested:** $Cdn |  | |
| *Amount must be under $10,000 CDN including taxes, delivery and installation* | | | | | |
| **Equipment Requested:** | |  | | |  |
| **Department Name:** | |  | | |  |

|  |  |  |
| --- | --- | --- |
| **Contact Person** | Name: |  |
| Email Address: |  |

Please answer Yes or No to the following questions:

|  |  |  |
| --- | --- | --- |
| Yes | No |  |
|  |  | Is this item currently on the approved FHA capital equipment list?  \*If not, please explain the rationale for the funds in the Description of equipment requested section \* |
|  |  | Do you have other funding sources for this equipment? |
|  |  | Have you applied to any other funds? Place circle all applicable Foundation funds  Caritas Fund Major Equipment Auxiliary Other: |
|  |  | Have supporting documentation been provided? Please attach - quotes, pictures, impact of use, etc. |

|  |
| --- |
| **Expected Purchase Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Note: Funds will be available for 3 months from the date of RCHF approval. After this period, re-approval is required) |

|  |
| --- |
| **Description of equipment requested:** |
|  |

|  |
| --- |
| **How will this equipment enhance patient care?** |
|  |

|  |
| --- |
| **How is this equipment new technology or innovative in the way it provides care?** |
|  |

|  |
| --- |
| **How often will the equipment be used each month? How many patients will the equipment treat each year?** |
|  |

|  |
| --- |
| **Do we have this piece of equipment on site already? If so, can it be shared?** |
|  |

|  |  |
| --- | --- |
| **Signatories** | |
| **Program Administrator**  Name (printed):  Title:  Signature: | **Program Director (required for requests $5,000+)**  Name (printed):  Title:  Signature: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOR RCHF OFFICE USE ONLY:** | | | | | | |
| Funding Decision: | |  | Amount Approved: | | |  |
| Peer Advised Impact Fund Committee Meeting Date: | | |  | | |  |
| **Committee Chair & Foundation Approval:**  Name: Jeff Norris | | |  | | |  |
| Signature: |  | | | Date: |  | |

# About the Peer Advised Impact Fund

The Royal Columbian Hospital Foundation established the Peer Advised Impact Fund to support the purchase of medical equipment from the proceeds of the RCH Staff 50/50 Lottery.

Applications will be accepted for hospital equipment under $10,000 (including all taxes, shipping) that will directly impact patient care at the hospital.

The fund will support:

* Equipment with demonstrated ability to improve patient comfort and/or care for a wide-range of patients
* Equipment that enhances a health care provider’s ability to more safely and effectively care for their patients
* Equipment that is new in technology or innovative in the way it provides care

Anyone working at the Royal Columbian Hospital is eligible to submit an application.

**Application Deadlines**

There are three funding periods per year. Applications for funding can be submitted at any time to the Foundation office, by fax to 604-520-4439 or by email to [annalissa.magleo@fraserhealth.ca](mailto:annalissa.magleo@fraserhealth.ca) . The submission deadline for each review is as follows:

|  |  |
| --- | --- |
| **Application Deadline** | **Committee Review &**  **Approval for Funding** |
| March 15 | April |
| July 15 | August |
| November 15 | December |