Facility Improvements and Enhancements Application

Form Preview

Applicant Details

* indicates a required field

Contact

Name *

First Name | Last Name

GCHHS ID No. *

Position *

Facility *

Unit *

Department *

Unit Address for Improvements *

Address

Suburb | State | Postcode

Must be an Australian postcode.

Delivery Instructions *

e.g. Robina Loading Dock

Phone *

Email *

Must be an email address.

Mobile Phone *

Project Details

* indicates a required field

Which departments will benefit from this program/equipment? *

List all that apply.

Will this project improve: *

- ○ One facility only
- ○ Multiple health facilities

Project Title

How many rooms will be enhanced by this project? *

Must be a number.

Description of the project and the health need/condition or illness it will address: *

Word count:
Must be no more than 100 words.
Provide a short description (100 words recommended) of your project - what are you out to do?

How did you identify the need for this project? *

Word count:
Must be no more than 150 words.

Describe a clinical scenario of how this project will improve patient outcome/s: *

Word count:
Must be no more than 150 words.
Please give a patient example to explain the benefit where possible.

Estimate the number of patients who will benefit from this project per year: *

Must be a number.

What is the most commonage group of patients who will benefit from this program/equipment item? *

- ○ Infants
- ○ Children
- ○ Adolescents
- ○ Young Adults
- ○ Adults
- ○ Elderly

If infant, children or adolescent then the application will be submitted to the GCHHS Women and Children Committee for assessing. Please do not select these if not relevant to predominantly relating to children.

What is the anticipated lifespan of this project and any items purchased? *

Items requested for project

Item requested (make and model)	Quantity requested	New or replacement
	Must be a number.	

Facility Improvement

Does the room/facility improvement relate to children? *

- ○ Child related
- ○ Not child related

If infant, children or adolescent then the application will be submitted to the GCHHS Women and Children Committee for assessing. Please do not select these if not relevant to predominantly relating to children.

Attach a completed and approved GCHHS Change form *

Attach a file:

The application cannot proceed without this signed authorisation.

How will you promote/inform the public of GCHF's participation in the project? *

Word count:
Must be no more than 150 words.

Budget

* indicates a required field

Funds requested

Total amount requested *

$

Must be a dollar amount.
What is the total financial support you are requesting in this application?

Is this equipment/project on the approved procurement list? *

○ Yes
○ No

Attach at least two quotes for the items requested:

First quote *
Attach a file:

Second quote *
Attach a file:

Explain if there is only one supplier available for these item/s

Other Funding Sources

Have you applied for or received other funding for this equipment/project? *

○ Yes
○ No

If yes, please specify

Funding source	Amount requested
	$

Total requested from other sources

$

This number/amount is calculated.

Related recurrent or maintenance costs

Cost	Amount
	$

Total recurrent/maintenance costs

$

This number/amount is calculated.

Will your Department/Unit support these costs? *

- ○ Yes
- ○ No

Certification

* indicates a required field

Applicant declaration

- I have read and understood the terms and conditions for Equipment and Facilities Enhancement Grant and agree to abide by those terms and conditions.
- I certify that to the best of my knowledge the statements made within this application are true and correct.
- All associated parts with this project have agreed that this application accurately represents the project.
- All needed authorisations and consents have obtained (patient case study, photos, etc.)

Name *

First Name Last Name

Date *

Divisional General Manager

As the applicants Divisional General Manager, I confirm the proposed equipment/project will enhance the Unit and improve patient outcomes as outlined in this application. I therefore endorse this application.

I confirm the above applicant will provide a case study report to Gold Coast Hospital Foundation involving a local patient within 60 days of receiving the equipment/project.

Name of Department Director *

First Name | Last Name

Click here to print the Department Director approval form and upload your completed form below. Applications can not proceed without authorisation.

Signed Department Director approval *

Attach a file:

The application cannot proceed without authorisation.

Click here to view the Terms and Conditions

Date *