Medical Equipment and Aids Application form 2022
Form Preview

Applicant Details

* indicates a required field

Contact Details

You must be a permanent GCHHS staff member to apply for funding. Temporary GCHHS staff members must be in their role of employment during the period in which the project is funded.

Name *
First Name Last Name

GCHHS ID No. *

Position *

Facility *

Unit *

Department *

Unit Location Equipment to be delivered *
Address

Suburb State Postcode

Must be an Australian postcode.

Delivery Instructions *

Ie. Robina loading Dock

Phone *

Must be an Australian phone number.

Email

Must be an email address.

Mobile Phone *

Must be an Australian phone number.

Equipment details

* indicates a required field

Name of equipment *

What type of equipment are you requesting? *
- ○ Medical Equipment
- ○ Medical aids for use by patients at home

Which departments will benefit from this equipment? *

Will this equipment item be used at more that one facility *
- ○ Yes
- ○ No

Description of the equipment 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 equipment item? *

Word count:
Must be no more than 150 words.

Describe a clinical scenario of how this equipment 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 equipment per year: *

Must be a number.

What is the anticipated lifespan of this equipment item? *

The equipment being applied for predominantly relates to: *

☐ Infants
☐ Children
☐ Adolescents
☐ Young adults
☐ Adults
☐ Elderly
☐ Other:

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.

Infants, Children or Adolescents has been selected. Do you agree that this application should be submitted to the GCHHS Women-Newborn-Children Committee for assessing? This Committee assesses applications predominantly relating to children

○ Yes
○ No

Equipment details

Quantity requested *

Must be a number.

Is this equipment: *

○ New
○ Replacement

Is this equipment currently being utilised in GCHHS? *

○ Yes
○ No

Is this item on a Standing Offer Agreement? *

- ○ Yes
- ○ No

The Standing Offer Agreement can be viewed Here

Does this piece of equipment link into the GCHHS network? *
- ○ Yes
- ○ No

Is this a medical electrical item? *
- ○ Yes
- ○ No

If yes, please provide your Cost centre number (for testing and tagging purposes):

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.

Does the total amount requested include equipment, delivery, handling and calibration costs, and GST where applicable. *
- ○ Yes
- ○ No

Will it require additional funding for installation? *
- ○ Yes
- ○ No

If Yes, amount required for installation:

$
Must be a dollar amount.

Is this amount included in the above stated Total Amount Requested?
- ○ Yes
- ○ No

Will your Department/Unit support these costs or are you wanting the Gold Coast Hospital Foundation to fund?
- ○ Department / Unit Funding
- ○ Gold Coast Hospital Foundation Funding

Attach three quotes for any item over $3,000

First quote *
Attach a file:

Second quote
Attach a file:

Third quote
Attach a file:

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

Preferred Supplier name and reason for preference:

Other Funding Sources

Have you applied for or received other funding for this equipment/project? *
- ○ Yes
- ○ No

Have you approached the Gold Coast Hospital Health Service to fund this item/s? *
- ○ Yes
- ○ No

If yes, please specify

Funding source	Amount requested
	$

	$
	$

If yes, please specify

Please supply the reason why the GCHHS will not fund this item/s

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 *

Department Director Authorisation

As the applicants Department Director, 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.

Click here to view a copy of the Terms and Conditions

Signed Applicant Declaration and Department Director Authorisation Form *
Attach a file:

The application cannot proceed without authorisation.

Date *