Medical Equipment and Aids Application form 26/27

Form Preview

Applicant Details

* indicates a required field

Eligibility Criteria

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.

As part of your acceptance of the generous gift from a valued Gold Coast Hospital Foundation Donor, you will be required to complete an Acquittal form. This form will be sent to you once handover of the item is completed. The submission will include a short video on how this donation has helped your patient care.

Name *

First Name Last Name

GCHHS ID No. *

Position *

Facility *

Unit *

Department *

Delivery Instructions *

Ie. Loading Dock

Unit Location for Equipment to be delivered *

Address

Suburb State Postcode

Must be an Australian postcode.

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

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.

The equipment being applied for predominantly relates to: *

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

What is the anticipated lifespan of this equipment item? *

Equipment details

Name of equipment *

Quantity requested *

Must be a number.

Is this equipment: *

○ New
○ Replacement

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

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

- ○ Yes
- ○ No

Attach three quotes for any item over $3,000

Please list in order of preference

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

Update quote
Attach a file:

Date quote updated

Must be a date.

Updated price

Must be a dollar amount.

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 Eligibility Criteria for Medical equipment & Aids Grant and agree to abide by the Eligibility Criteria.
- I certify that to the best of my knowledge the statements made within this application are true and correct.
- All stake holders contributing to this project have agreed that this application accurately describes the project.
- All required authorisations and consents have been obtained (patient case study, photos, etc.)

I have read and agree to the terms and conditions *

Declarant Name *
First Name Last Name

Date *

Name of Department Director *
First Name Last Name

Click here to print the GCH Foundation Approval Form and upload your completed form below. Applications cannot proceed without authorisation.

Signed Department Director approval *
Attach a file:

The application cannot proceed without authorisation.

Click here to view the Terms and Conditions

I have read and agree to the terms and conditions *
○ yes

Date *