

## CICF Educational Grant Funding Form

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Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

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Submission Amount Requested: \$ \_\_\_\_\_ (not exceeding \$5,000)

Are you a member of the CICF (see eligibility criteria)?  Yes  No

Do you work either part-time or full-time in a Critical Care environment?  Yes  No

Please indicate the discipline in which you are a registered practitioner:

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Medicine    | <input type="checkbox"/> Nursing              | <input type="checkbox"/> Respiratory Therapy                |
| <input type="checkbox"/> Pharmacy    | <input type="checkbox"/> Dietary              | <input type="checkbox"/> Physiotherapy/Occupational Therapy |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Other, specify _____ |   |
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**If Applicable:**

Date of Event: \_\_\_\_\_

Location of Event: \_\_\_\_\_

Number of participants: \_\_\_\_\_

Name of Visiting Speaker: \_\_\_\_\_

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State what are the Educational Goals and Objectives of the activity / event:

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Elaborate on how the activity/event is aligned with the CICF Mission and Vision

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Budgetary justification for the amount requested:

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*Signature of Applicant*

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*Date*

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