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Providing the Best Healthcare Close to Home
Charitable #14091 0399 RR0001

CAPITAL EQUIPMENT GRANT APPLICATION

Contact Information:

Contact Name: _____ Phone No: _____

Email: _____

☐ Nipawin Hospital ☐ Pine View Lodge ☐ Carrot River Health Centre
☐ Arborfield Health Centre ☐ Cumberland House Health Centre

Department _____

Request:

Equipment request _____

This equipment is: ☐ Replacement ☐ New ☐ Essential ☐ Luxury/Enhancement

Please provide details regarding how the requested equipment will benefit clients/patients, staff and/or overall operation within the healthcare facility. Additional pages may be attached if required.

Please provide approximate costs and names of potential equipment suppliers.

**In practice, two quotes should be provided unless there is an internal policy, IE. SHA, for single source providers for product continuity, bulk purchasing power or only provider available, or if the quote has already gone through procurement and has been rejected.*

If this item is not funded, how will this affect the operation of the department/area of the healthcare facility? Additional pages may be attached if required.

Has a request been made to the SHA? Yes____ No _____

If Yes, when? _____

If the request was declined, please advise us of why the request was denied.

Facility Administrator: _____
Signature or Email acknowledgement Date

Director: _____
Signature or Email acknowledgement Date

For NRHF office use only:

Date reviewed by NRHF Board of Directors _____

Is this a shared-funding equipment purchase? Yes____ No _____

Comments:

Date approved: _____

Funding source: _____

Executive Director _____ Date _____
NRHF