**Wellington Hospital Chaplaincy Trust Grant Application Form**

**This form is for applications for grants from the Wellington Chaplaincy Trust Board (Trust).**

*Notes for applicants:*

* *Please review the grants policy before lodging your application. It is available on the Trust’s website****: www.whct.org.nz/grants-policy***
* *While we encourage you to use this form, you may provide the same information in another format, provided you are able to lodge the form digitally.*
* *The space provided for each section of the application is indicative only but applications should be no more than two pages.*
* *Please email the completed application (in this form or another) to:* ***whctor2@whct.org.nz*** *The Trust will endeavour to respond to applications within three months of receipt.*
* *Please direct your referees to separately email their statements of support for your application.*

**Please complete all sections of this application and return to Wellington Hospital Chaplaincy Trust   
at the address below with any relevant attachments.**

|  |  |
| --- | --- |
| Name of Organisation: |  |
| **Address:** |  |
| **Telephone:** |  |
| **Contact Person:** |  |
| **Email Address:** |  |

**Please provide a description of the project (including who will benefit) in the panel below.   
Please attach any additional supporting information if required.**

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|  |  |  |
| --- | --- | --- |
| **Amount applied for** | **Total cost of the project** | **Funds already available** |
| $ | $ | $ |

**Referees**

Please supply details of two referees for your project:

|  |  |  |
| --- | --- | --- |
|  | **Referee 1** | **Referee 2** |
| **Name** |  |  |
| **Address** |  |  |
| **Phone** |  |  |
| **Email** |  |  |

**Other grants applied for:**

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Please include a copy of the following (Please tick to indicate you have included):

Application form

Other supporting documentation that is deemed appropriate

Pre-Printed Bank Deposit Slip

I/We the applicant(s) confirm that I/we have read and accept the application guidelines and   
I/We acknowledge that if a grant is made my/our organisation may be asked to acknowledge the grant from Wellington Hospital Chaplaincy Trust publicly.

I/We the applicant(s) confirm that Wellington Hospital Chaplaincy Trust may collect information about our organisation from third parties in respect of this application.

|  |  |  |
| --- | --- | --- |
| Name | Position | Date |
|  |  |  |
| Name | Position | Date |
|  |  |  |

###### NB: Please retain a copy of this form for your records

|  |  |
| --- | --- |
| Office Use Only: | Approved or Declined: |
| Amount Recommended: | Comments:  Reference No: |