



APPLICATION FORM FOR DREAM OR QUALITY OF LIFE INITIATIVE

Details of this form must be completed in full and signed by a parent and/or guardian.

Relay your intentions to your child's doctor and ask him/her to write a note confirming your child's diagnosis and prognosis. Please provide as many details as possible. This will avoid delay. Attach the doctor's note to the application form.

Email or scan the completed application form with doctor's note to contact@helpfilladream.com. You can also mail or fax it.

Also, enclose a picture of your child (if possible), for our records.

May we take this opportunity to say thank you for allowing us to share the Dream of your wonderful child.

*Please note: we cannot commence processing an application until we receive the above items, "**D**" and "**R**"*

APPLICATION FORM FOR DREAM OR QUALITY OF LIFE INITIATIVE

Child's Name: _____ Male ___ Female ___

Birthdate: _____ Telephone: _____

Parent/Guardian's Name(s): _____

Address: _____

City: _____ Postal Code: _____

Email: _____ Cell #: _____

Child's Condition: _____

Physician's Name: _____

Telephone: _____ Hospital: _____

Dream Request: _____

OR

Quality of Life Initiative: _____

Comments: (please feel free to add an additional page if more room is required)

Child's interests, hobbies, favourite sports/players, celebrities:

The parent(s) or guardian(s) will not hold Help Fill A Dream Foundation, or its' officers, staff, members, or volunteers responsible for any accidents, acts of God or unforeseen illness that could occur during this dream or quality of life initiative.

Date of Application: _____

Parent/Guardian Signature: _____

PLEASE NOTE: A note from the child's physician must accompany this application.

QUESTIONNAIRE

- 1) Do we have permission to use and/or publish your name, your child's name and appropriate pictures for the purpose of raising public awareness regarding the Foundation's provisions of dreams and other services? Yes _____
No _____
- 2) Are there any special medical requirements such as: medication, wheelchair, and/or stretcher? If so, please state below: Yes _____
No _____

- 3) Have you ever received funds from any organization such as Help Fill A Dream, Children's Wish, Make A Wish etc? Yes _____
If yes, please provide details. No _____

- 4) Would this Dream or Quality of Life Initiative be possible if you were not financially assisted or sponsored by Help Fill A Dream? Yes _____
No _____
- 5) Are you and your family, in any way, related through blood or marriage to any members or associates of this Foundation? Yes _____
No _____

PRIVACY:

The Help Fill A Dream Foundation is committed to protecting the privacy of the personal information of our Dream children, their families, our donors, our employees, our members and volunteers, and other stakeholders. The Help Fill A Dream Foundation acts in accordance with the privacy principles found in the federal Personal Information Protection and Electronic Documents Act. These principles address the collection, use, storage and disposal of personal information.

INDIVIDUAL INFORMATION:

Help Fill A Dream collects information to facilitate the delivery of our programs to children with life threatening illnesses. In the absence of express written permission, disclosure of such personal information to third parties is limited to providing only such information as is necessary to those third parties who need to receive it in order to deliver the program to the children and their families. The personal information and disclosure of that information necessary for the purpose of delivering the program is authorized by the recipient's custodial parent(s) or legal guardian by signed approval at the time of collection.

SAFEGUARDS:

Help Fill A Dream ensures that all personal information collected, retained and destroyed is protected against loss, theft, unauthorized access and inadvertent or inappropriate release.

Procedures have been established to ensure that the personal information is collected used, stored and destroyed in a sensitive manner. This information is considered and treated as highly confidential.

PRIVACY OFFICER:

Help Fill A Dream Foundation's Privacy Officer can be contacted for any inquiries regarding the appropriate collection, use, disclosure, retention, and destruction of personal information. Program recipients and donors can request access to their own personal information through the Privacy Officer as well.

CONTACT INFORMATION:

Help Fill A Dream Foundation
 Unit D – 4085 Quadra St
 Victoria BC V8X 1K5
 Tel: 250-382-3135 Fax: 250-382-2711
 Toll Free: 1-866-382-2711
www.helpfilladream.com
contact@helpfilladream.com

For HFAD Office Use Only:

Date Application Received:

Doctor's note attached: yes no

Life-Threatening Condition: yes no

Board Approved: yes no

Comments: