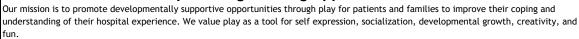
Golisano Children's Hospital Programming Application





Program Information						
Name					Contact Person	Email
Street Address		City	y	ST	Zip	Phone
Have you ever done a special eve	no Childre	n's Hospital?	If yes, who was yo	ur contact person?		
Program Description						
Description of program:						
Number of people in your group? (Max 5)						
Age range of group? (Min 14)						
Event Type? (Circle One)	Activity Performance Other					
Length of Performance? (Circle One)	30 Minutes 45 Minutes 60 Minutes 90 Minutes					
Set-Up Time Required? (Circle One)	None 10 Minutes 20 Minutes >30 Minutes					
Breakdown Time Required? (Circle One)	None 10 Minutes 20 Minutes >30 Minutes					
Bringing Supplies? (All supplies must be provided by the group)	Yes No (All Supplies must be approved prior to the event)					
Arrive in clean costume?	Yes	No	N/A	If no, do you need prepare		
Do you intend on offering gifts? (Gifts must be approved prior to distribution)	Yes	No		If yes, describe:		
Equipment Needs? (Circle all that apply)	Tables Chairs Electrical Outlet Access Other:					
Parking Needs? (Circle One)	Car Bus Van Number of Vehicles?					
Previous Program Presentations						
Location				Contact Person		Phone Number
Date and Time Preference						
Preferred Date:	First Alternate Date:			Second Alternate Date:		
Preferred Time:	First Alternate Time:			Second Alternate Time:		
Submission						
Please si	uhmit to CI	SpecialFye	nts@urmc_roches	ter edu at least on	e month prior to pre	ferred date

Please submit to CLSpecialEvents@urmc.rochester.edu at least one month prior to preferred date Please submit at least two months prior for holiday dates. All programming is subject to change based on the status and needs of the hospital.

All programming is subject to change based on the status and needs of the hospital. You will be informed as early as possible should rescheduling be required.