# MINOR TENANT IMPROVEMENT FUNDING SUBMISSION FORM

***Please submit this form to*** ***lpottinger@doctorsofbc.ca*** ***and copy your PCT Partner***

|  |  |
| --- | --- |
| **Submission Date** |  |
| **Division Name** |  |
| **Executive Director** **Name** |  |
|  | **Email** |  | **Phone** |  |
| **Signature** |  |
| **PCN Steering Committee Co-Chair (Physician)** **Name**  |  |
|  | **Email** |  | **Phone** |  |
| **Signature**  |  |
| **PCN Steering Committee Co-Chair (Health Authority)****Name**  |  |
|  | **Email** |  | **Phone** |  |
| **Signature**  |  |

***If the CSC is acting as the PCN Steering Committee, please have the CSC Co-Chairs sign this form***

|  |  |
| --- | --- |
| **GP Name** |  |
| **Private Clinic Name** |  |
| **Private Clinic Address** |  |
|  | **Email** |  | **Phone** |  |
| **Briefly describe the requirements and alignment with PCN service plan approvals.****Please include # of rooms & square feet needed to accommodate new inter-professional team members.** **(max. 250 words)**  |  |
| **Number of new inter-professional team members (RNs/LPNs/ AHPs) that will be added to the practice (per approved service plan)** | X RNX LPNX AHP |
| **Number of hours of service per week that each new inter-professional team member will be providing at the clinic. (Minimum required is 60% time)**  | X RNX LPNX AHP |
| **Type of expenses *– Check all that apply*** | [ ] Design and contracting[ ] Floor and wall covering[ ] Ceilings[ ] Partitions[ ] Electrical | [ ] Plumbing[ ] Fire Protection[ ] Security[ ] Others, please specify: |
| **Total estimated cost – *Please attach the quote from the contractor*** |  |
| **Funds requested - *GPSC will contribute 85% of the cost, at maximum of 2 rooms per clinic @$41K per room*** |  |

**By requesting this funding, we certify that the recipient:**

* **is a private GP owned or leased clinic participating in the local Primary Care Network; and**
* **has confirmed their commitment to continue operating in the renovated space.**