Community Initiatives Funding
Claim Form

Name of event: _____

Date of event: _____

Location: _____

Number of participants: _____

Purpose for funding: _____
(Healthy food, snacks, program materials, etc.)

Funding requested by: _____
(Name of person making the request)

Name and FULL mailing address of person/organization to be reimbursed:

_____

_____

_____

Amount CRWC approved: $_____

Amount being claimed $_____
(Original Receipts must be attached and sent with claim form, photocopies will not be processed. All claims must be submitted for reimbursement within 30 days after the event occurs.)

Mail claim form with original receipts to either:

Jill Wheaton (Co- Chair)
Bell Place Community Health Centre
3 Bell Place, Level 1
Gander, NL
A1V 2T4

Allison Vincent (Co-Chair)
Notre Dame Bay Memorial Health Centre
7-11 Hospital Lane
Twillingate, NL
A0G 4M0

********** **Original receipts attached?** **********