



**PAWS
OF
CNY**

**HOSPITAL FACILITY
APPLICATION**

CONTACT INFORMATION

Hospital Name: _____

Street Address: _____

City/Town: _____ State: _____ Zip: _____

Unit Name: _____

Contact Person for Unit: _____

Phone: _____ Email: _____

Alternate Contact Person: _____

Phone: _____ Email: _____

VISIT INFORMATION

Please indicate the day(s) and times that are most convenient for SFI volunteers to visit.

Monday: _____ Friday: _____

Tuesday: _____ Saturday: _____

Wednesday: _____ Sunday: _____

Thursday: _____

Please choose & complete either Section A or Section B below.

- A. GROUP SESSIONS: SFI volunteers will visit with a group of residents/patients at the designated day and time in a specified area or room in your facility.

Approximately how many patients will be attending the visits? _____

- B. INDIVIDUAL SESSIONS: SFI volunteers will visit one-on-one with patients at your facility during the designated day and time.

Approximately how many patients will receive visits at each session? ____

Please note any special regulations and/or requirements pertaining to your unit that we need to be aware of:

PAWS of CNY, Inc. is a non-profit organization and would appreciate a small donation for services if possible