

## FUNDING CONFIRMATION FORM

Purpose: For a third party to commit funding towards an operating or capital expenditure by Interior Health

Please email completed and signed form to:  
[CapitalAccountingForms@interiorhealth.ca](mailto:CapitalAccountingForms@interiorhealth.ca)  
Phone: 250-342-2301 Fax: 250-342-2306

<b>Third Party Donor Information</b>	
Name	<b>SOUTH CARIBOO HEALTH FOUNDATION</b>
Address	<b>BAG 399 - 555D CEDAR AVENUE 100 MILE HOUSE, BC V0K 2E0</b>
Attention	<b>Richard Bullen</b>
Email	[REDACTED]
Phone	[REDACTED]
FCF #	

Facility	<b>100 Mile District General Hospital</b>
Department Manager	<b>Kathy Munroe</b>
Department Name	<b>OMH ER</b>
Department Cost Centre	<b>1 2 7 0 . 7 1 . 3 1 0 2 0 0 0</b>
Operating EOC	<b>9401038 Equipment Donations</b>
<b>Donor Sensitive Items:</b> Invoice must be received by the Third Party Donor prior to the following date (dd/mm/yyyy)	
<b>Donor Approval for Price Variances:</b> Maximum Contribution of \$ OR <input checked="" type="checkbox"/> Up to 10% of Contribution	

Capital Number	Description	Fund (if applicable)	Replace or Add	Cost per Item (A)	Tax Rate (Required)	Net Tax (B)	Total Cost per Item (C = A + B)	Qty (D) (Required)	Total Cost (C x D)	Donor Confirmed Contribution (Required)
	<b>Morgue Racking System</b>		<b>Add</b>	<b>8,475</b>	<b>Both</b>	<b>666</b>	<b>9,141</b>	<b>1</b>	<b>9,141</b>	<b>9,141</b>
	<b>Morgue Lift</b>		<b>Add</b>	<b>22,190</b>	<b>Both</b>	<b>1,742</b>	<b>23,932</b>	<b>1</b>	<b>23,932</b>	<b>23,932</b>
<b>Total \$</b>									<b>33,073</b>	<b>33,073</b>

Authorized by	Name	Signature	Date (dd/mm/yyyy)
1. Site Administrator or Program Director	<b>Kelly Dillon</b>	[REDACTED]	<b>11Apr2023</b>
2. Director of Business Support or Designate (required for purchases greater than \$5,000.00 in total)	<b>Cinda Carlston</b>	[REDACTED]	
3. Authorized Signing Officer of Third Party Donor (Third Party Donor is responsible for payment to IH upon receipt of IH invoice)	<b>Richard Bullen</b>	[REDACTED]	<b>11Apr2023</b>