BURLINGTON WELLNESS COMMITTEE

wellness@burlingtonvt.gov

EQUIPMENT OR PROGRAM REQUEST FORM

Use this form to request funding for equipment installation or for a proposed program. Email all requests to wellness@burlingtonvt.gov. Requests are reviewed and presented to the full committee before being scheduled for approval by the committee.

DEPARTMENT NAME: _____
ADDRESS: _____
DEPARTMENT HEAD OR SUPERVISOR: _____
SIGNATURE: _____
APPLICANTS NAME: _____
CONTACT TELEHONE # OR E-MAIL ADDRESS: _____
DEPARTMENT WELLNESS COMMITTEE MEMBER NAME: _____
DATE OF APPLICATION: _____

PLEASE INDICATE IF YOU ARE REQUESTING FUNDING FOR:
_____ EQUIPMENT
_____ PROGRAM
(NOTE: MAINTENANCE OF EQUIPMENT IS THE RESPONSIBILITY OF DEPARTMENTS)

COMPLETE INFORMATION FOR EQUIPMENT (SECTION 1) OR PROGRAM (SECTION 2)

SECTION 1-EQUIPMENT
DESCRIPTION:
_____
_____
_____
_____
_____

EQUIPMENT (CHECK ONE): ____ NEW ____ REFURBISHED ____ REPLACEMENT

IF REPLACEMENT, HOW LONG HAS YOUR DEPARTMENT HAD THE EQUIPMENT YOU WOULD LIKE TO REPLACE:
_____

IS THE CURRENT EQUIPMENT WORKABLE: ___ YES ___ NO
TRANFERRED TO OTHER DEPARTMENT: ___ YES ___ NO

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NAME OF DEPARTMENT: _____

HOW MANY HOURS IS THE EQUIPMENT USED DURING AN AVERAGE WORK WEEK: _____ HOURS

EQUIPMENT JUSTIFICATION TO RECEIVE FUNDING PER YOUR REQUEST:

_____

_____

_____

_____

_____

HOW LONG DO YOU EXPECT THIS EQUIPMENT TO LAST WITH REQUIRED MAINTENANCE:

_____

EQUIPMENT TO BE USED FOR (CHECK ALL THAT APPLY)

___ REGULAR EXERCISE (DAILY)
___ USED ONLY ON BREAKS OR LUNCH PERIOD
___ WEEKENDS
___ EVENINGS / AFTER NORMAL WORK HOURS
___ BY STAFF
___ BY FAMILIES OF STAFF
___ MULTIPLE DEPARTMENTS

LOCATION OF EQUIPMENT:

BUILDING OR DEPARTMENT: _____

TYPE OF ROOM (DESCRIPTION)

_____

_____

NAME OF DEPARTMENT STAFF RESPONSIBLE FOR EQUIPMENT:

_____

COST OF EQUIPMENT: $ _____

NOTE: THREE (3) QUOTATIONS REQUIRED OR ACCEPTED REASON FOR NOT PROVIDING QUOTATIONS. VENDOR NAME / ADDRESS:

1) _____

_____

2) _____

_____

3) _____

_____

SECTION 2 – PROGRAM INFORMATION

PROGRAM NAME:

_____

_____

PROGRAM DESCRIPTION:

_____

_____

_____

_____

SPONSOR OR VENDORS NAME OF PROGRAM PROVIDOR:

_____

_____

PROGRAM IS AVAILABLE TO (CHECK ALL THAT APPLY)

___ STAFF

___ FAMILY MEMBERS OF STAFF

___ FORMER CITY EMPLOYMENT (RETIRED)

PROGRAM LEAD BY:

___ INSTRUCTOR

___ SELF INSTRUCTION

___ VIDEO

___WRITTEN MATERIAL

___ OTHER (DESCRIBE)

_____

_____

WHAT IS THE DURATION OF THIS PROGRAM, _____ DAYS OR _____ WEEKS

NUMBER OF SESSIONS:

_____

NUMBER OF CLASS LIMIT PER SESSION: _____

SCHEDULED DATES OF PROPOSED PROGRAM:

FROM: _____ TO: _____

LOCATION OF PROGRAM:

_____

_____

COST OF PROGRAM (TOTAL)

_____

COST PER PERSON (TOTAL)

_____

NOTE: THREE QUOTATIONS (3) REQUIRED OR ACCEPTED REASON FOR NOT PROVIDING QUOTATIONS.

1) _____
   _____
2) _____
   _____
3) _____
   _____