

## DESCRIPTION OF APPLICANT (FOR ORGANIZATIONS)

Are you a non for profit organization?  Yes  No

Name of your organization: \_\_\_\_\_ Status (Association, foundation, etc.): \_\_\_\_\_

Number of employees: \_\_\_\_\_ Number of voluntary workers: \_\_\_\_\_

Mission (Attach details): \_\_\_\_\_

Partners: \_\_\_\_\_

Accomplishments in the hearing health care area: \_\_\_\_\_

Balance sheet (attach financial statements for last 3 fiscal years): \_\_\_\_\_

Contact person's name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Web Site: \_\_\_\_\_ Email: \_\_\_\_\_

## DETAIL OF APPLICATION

Your application concerns:

A hearing aid for an individual (Explain his/her situation and needs in attachment).

An assistive listening device for an individual (Explain his/her situation in attachment).

Professional services. Specify which ones (Audiological, audioprosthetic, other): \_\_\_\_\_

Training activity. Specify which one in attachment (attach coordinates of the contact as person in charge): \_\_\_\_\_

Research fund (Attach details of your research project and explain how we can assist you (Purchase of equipment, funding, cooperation with professionals in our group, etc.)).

Support in fund raising campaign (Explain how we can help you, what visibility can be offered in exchange for our support and what cause will benefit from the funds).

Support for a public awareness event (Explain how we can support your project and what visibility we can derive from such support).

## DETAIL OF PROJECT

What are the other partners in this project (Confirmed or solicited)? \_\_\_\_\_

What will be the total budget for this project? \_\_\_\_\_

What portion will be financed through your partners? \_\_\_\_\_

How many employees/volunteer workers are dedicated to this project? \_\_\_\_\_

Describe what clientele is being targeted by this project: \_\_\_\_\_

Describe the project's impact on hearing health care: \_\_\_\_\_

How will you communicate the results to your partners? (Attach your communication protocol or explain when it will be available) \_\_\_\_\_

I hereby confirm that the information provided in this donation request form is accurate and complete to the best of my knowledge.

X \_\_\_\_\_ Day / Month / Year

User or authorized person

## CONSENT FOR THE COLLECTION AND USE OF PERSONAL INFORMATION

I, the undersigned \_\_\_\_\_ Organization name \_\_\_\_\_

I authorize the Fondation Groupe Forget, upon the opening of my donation request file or for its update, to collect my personal information for the purposes listed hereafter, which are necessary for the evaluation of my request:

- Evaluation of my hearing needs using a recent audiogram, audiological history, and a letter describing my activities, current hearing devices, and needs;
- Obtaining and reviewing the patient file from Polyclinique de l'Oreille and/or Groupe Forget and/or an Otolaryngologist (ENT doctor), if applicable;
- Gathering additional information from professionals consulted at Polyclinique de l'Oreille and/or Groupe Forget and/or an Otolaryngologist (ENT doctor);
- Evaluation of my financial capacity using the latest property tax statement and assessment notices of the applicant and their spouse, if applicable;
- Ordering of hearing aids, parts, and accessories related to hearing health, including orders placed with suppliers located outside of Quebec;
- Transfer of personal information to relevant hearing healthcare professionals;

My personal information may be collected upon receiving the donation request, through phone calls, emails, or any other follow-ups within the context of my donation request to the Fondation Groupe Forget. All collected personal information is recorded in my donation request file, which can be stored in paper, electronic, or cloud-based formats.

At any time, I can access the personal information about me, request its correction if needed, or withdraw my consent to the retention, communication, or use of the collected personal information.

I expressly consent to the collection, retention, and use of my personal information for the aforementioned purposes and methods, and if necessary for the execution of the given mandate, the transfer to a third party in Quebec or outside Quebec, by the Fondation Groupe Forget.

My consent is clear, free, and informed, and it remains valid until its withdrawal or until the Fondation Groupe Forget has completed the review of the donation request file.

X \_\_\_\_\_  
User or authorized person

\_\_\_\_\_  
Day / Month / Year