Date Received: _____

APPLICATION FOR COMMUNITY GROUPS/VISITORS
CARILION CHILDREN'S HOSPITAL

Please return this application to: Child Life Department
11 South Pediatrics
Carilion Roanoke Memorial Hospital
1906 Belleview Ave.
Roanoke, VA 24014
Fax: 540-344-2381

Name of Group/Individual _____

Address: Street Number _____

City/ State/ Zip Code _____

Contact Person: _____

Day Time Phone: _____ Email: _____

Number of Persons in Group * _____ Ages * _____
(Must meet criteria in Visitor/Community Group Guidelines)

What do you plan on providing while visiting Carilion Children's Hospital? (Please circle all that apply)

Pre-Planned Activity Entertainment/Performance Gift Donation

Please Describe:

_____

_____

Will you need any special equipment or space during your visit? YES NO (Circle One)
If yes, please describe: _____

Circle the Date and Time below you wish to make your visit:
(Refer to Visitor/Community Group Guidelines)

Weekday *First* Choice:
Mon. date_____ Tue. date_____ Wed. date_____ Thu. date_____ Fri. date_____

Time *First* Choice:
10am-11am 11am-12noon 1pm-2pm 2pm-3pm 3pm-4pm

Weekday *Second* Choice:
Mon. date_____ Tue. date_____ Wed. date_____ Thu. date_____ Fri. date_____

Time *Second* Choice:
10am-11am 11am-12noon 1pm-2pm 2pm-3pm 3pm-4pm

I have read the Visitor/Community Group and Toy Safety Guidelines for Carilion Children's Hospital and affirm my/my group's willingness to adhere to these guidelines.

Signature: _____ Date: _____