Medicine Hat

JOINT USE APPLICATION FORM

APPLICATION/ORGANIZATION CONTACT INFORMATION		
Organization Name:	Organization Contact Name:	
Organization Mailing Address/Postal Code:		
Telephone Number:	Cell Number:	
Fax Number:	E-mail Address:	
FACILITY REQUEST INFORMATION		
Preferred Facility (First Choice):	Preferred Facility (Second Choice):	
Day of the Week – Start and End Date (First Choice):	Start Time:	End Time:
Day of the Week – Start and End Date (Second Choice):	Start Time:	End Time:
If you are requesting more than one day a week or specific days each month, please attach your list or specific dates on another page. **All of the information must be completed and submitted using this request form**.		
PROGRAM INFORMATION		
Name of the Program/Activity/Event:	Adult (18 years plus) ☐ # of participants. _____ Youth (under 18) ☐ # of participants. _____ (At least 75% of participants are under 18) Mixed ☐ No. _____	
Number of Teams (if applicable): _____	Total Number of Participants: _____	

Are you applying on behalf of a Team/ Individual: ☐ Yes ☐ No Team Name: _____	Are you applying on behalf of a League: ☐ Yes ☐ No League Name: _____

Are you registered under the Societies Act as a not-for-profit organization? ☐ Yes ☐ No

If Yes, What is your Corporate Registry Number? _____
(Corporate Registry Number can be found on your Certificate of Incorporation) – **(A copy of certificate of insurance is required)**

Do you carry the required liability insurance? (minimum 2 million) ☐ Yes ☐ No

If Yes, Name of Insurance Company, Policy Number, Expiry Date:_____
(A copy of certificate of insurance is required)

If No, please see the Eligibility Criteria of User Groups

The personal information collected on this form will be used to administer facility bookings under the Joint Use Agreement for the City of Medicine Hat. This personal information is being collected in accordance with the Freedom of Information and Protection of Personal Privacy Act and will only be shared with third parties with your written permission.

Please mail, deliver, fax or email a copy of this form to:

RECREATION FACILITY COORDINATOR
2000 DIVISION AVE N
MEDICINE HAT, ALBERTA. T1C 1X9
Fax: 403.502.8561
e-mail: susmcd@medicinehat.ca

I agree that the information above is correct: ☐

Office Use Only: Date Received: _____ Notification – School : ☐ Yes ☐ No Applicant : ☐ Yes ☐ No	Approval: ☐ Yes ☐ No Insurance: ☐ Yes ☐ No

Eligibility Criteria for Joint use facilities:

1> Approved application will require the following:
- Insurance certificate (2 million liability insurance)
- Residency (see next page)

*****Please note this is an application from only, final approval depends on a review of all applications*****

Please accept this form as my application for the facilities indicated above. I hereby state the facilities have been requested exclusively for the group I represent. As the Permit holder, I understand that I must notify the Recreation Facility Coordinator one month prior for tournaments and 5 business days for single bookings for cancelations.

Residency:

I _____representing the applicant for the Community User Group approval, confirms that:

- ☐ Generally our group has a minimum of 75% City of Medicine Hat residents; and
- ☐ Generally our group has a minimum of 12 participants per booking.

Note: Participant Rosters are not required.

_____	_____	_____
Printed Name	Signature	Date