



## Phoenix Children's Patient Event Application

Today's Date:

Group Name:

Event Contact Person:

Phone Number:

Email:

Address:

City:

Zip Code:

Detailed Description of Event/Visit:

Anticipated Length of Event/Visit:

Total Number of People Involved in Event/ Roles in Event:

If a children's group, please provide the range of ages that would be participating:

Time frame you are available for event (months, days of the week, times):

Please list a link to your website or video (if applicable).

Please list other hospitals or venues in which this event/service was provided:

\*Please attach pictures of costumes (if applicable).

Do you plan to (all items require prior approval):

a) Bring giveaway items for patients? Yes No

If yes, please describe:

b) Bring food or beverage items for patients? Yes No

If yes, please describe:

c) Notify media? Yes No

If yes, please describe:



**Do you require the following? (please check applicable and describe)**

a) **Assistance with parking? Yes    No**

If yes, please describe:

b) **Assistance with transporting supplies? Yes    No**

If yes, please describe:

c) **Assistance with set-up? Yes    No**

If yes, please describe:

d) **Changing area? Yes    No**

If yes, please describe:

e) **Other:**

**Note:** No pictures of patients are allowed to be taken during events without prior approval.  
No additional guests/observers are permitted to accompany event other than those directly involved.

Thank you for your interest in bringing smiles to our patients and families at Phoenix Children's!  
We review applications monthly. If your application aligns with current hospital event parameters and goals, you will be contacted by the hospital event coordinator.

For questions, please email [patientevents@phoenixchildrens.com](mailto:patientevents@phoenixchildrens.com).