**Visiting Group Application**

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| Applicant information |
| Contact Person Name: |
| Organization Name (if applicable): | Phone: |
| Address: |
| City: | State: | ZIP Code: |
| Email Address: |
| Visit inforamtion |
| Please circle one: Activity Visitor Community Celebrity Performance  |
| Detailed Description of Visit Request: |
| Total number of visitors:  | Ages: |
| Media Coverage or Photos Desired: Y N (please provide more detail in above description) |
|  |
| Activity Visitors are invited April-November, M-F from 11am-2pm. Community Celebrities are invited year round, M-F from 10am-4pm. Please mark your first and second choices below. |
| First Choice | Date: | Time: |
| Second Choice  | Date: | Time: |
|  |
| By adding your name below, you are stating that you have read the “Visitor Guidelines” for St. Luke’s Children’s Hospital and affirm you/your group’s willingness and agreement to adhere to these guidelines.  |
| Name: | Date: |
| Please email completed application to:childlifeservices@slhs.orgfor questions, please call:(208)381-4758**Please allow up to one week for reply** |
| **for office use only** | Date Received: | Approved: Y N | Day/Time: |
| Media/Photos approved: Y NDetails: | Comments: |

**Please review “Visitor Guidelines” before completing this application.**