



**APPLICATION FOR
ENTERTAINMENT GROUP**

Name of Group/Performance _____

Contact Person _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Address _____

City _____ State _____ Zip Code _____

E-mail _____

Description of Presentation _____

Number of persons in your group _____ Target audience age group _____

Facilities and/or Equipment needed _____

Are you planning on handing out gifts? YES NO

If yes, please provide a detail description of what you will be bringing. (*All gifts must be religiously neutral and be appropriate for children ages 0-21—please feel free to contact the child life department for ideas.*)

*****All gifts must be in quantity of 100 if they are to be passed out to children.**

Proposed date of visit _____ Time _____

Alternate date of visit _____ Time _____

Is media coverage being sought? YES NO

If yes, a copy of any press release must be submitted to the Public Relations Department at least one week prior to your visit. (PR contact: Amy Gall 813-870-4731)

If appropriate, is video taping allowed so that patients may watch the performance on in-house CCTV? YES NO

As a representative of the above named organization, I have read the guidelines for entertainers or groups visiting St. Joseph's Children's Hospital and agree to adhere to the said requirements.

Please initial:

____ I understand that all community visitors must be at least 14 years old.

____ I understand that I must submit this application at least 2 weeks prior to visit.

____ I understand that entertainment groups must contain less than 10 people.

____ I understand that due to privacy laws, I may not ask patients or families any questions regarding their diagnosis, age, length of stay, or plan for going home.

____ I understand that any presentations or gifts must be politically and religiously neutral.

____ I understand that photographs of patients and families may not be taken by visiting groups or individuals.

____ I understand that all gifts must be of the same type, appropriate for patients ages 0-21 and in quantities of 100.

Print Name: _____

Signature: _____

Date: _____

****Please return this form at least 2 weeks prior to proposed performance date to:***

Leah Class M.S., CCLS
Child Life Department
St. Joseph's Children's Hospital
3001 W. Dr. Martin Luther King Jr. BLVD
Tampa, FL 33607