

# Hospital LED Lighting Retrofit Application Form

## Facility Information

Hospital Name

Facility ID (if applicable)

Address

City

State

ZIP Code

## Contact Information

Contact Name

Title/Role

Phone

Email

## Project Information

Describe Project Scope

Hospital Areas Involved (select all that apply)

Wards/Patient Rooms  
Hallways/Corridors  
Operating Theatres  
Offices/Admin



Offices/Admin  
Laboratories  
Emergency Department  
Other



Number of Existing Fixtures

Number of Proposed LED Fixtures

Estimated Start Date

Estimated Completion Date

Additional Notes