

**Regional Hospital District**  
**Request for Long-Term Financing**

Regional Hospital District Name:

Capital Bylaw #:

Request is for MFA's debt issue in the Spring of 20\_\_\_\_  
Fall of 20\_\_\_\_

Term Requested:

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**Reconciliation**

(Please only use RHD share in these calculations)

Capital Bylaw Total Borrowing Authorized:	\$ _____
Less: Portion previously converted to debenture (if applicable)	\$ _____
Subtotal	\$ _____
Less: Temporary borrowing outstanding (if applicable)	\$ _____ (A)
Balance:	\$ _____ (B)
NET AMOUNT REQUESTED: (Cannot be greater than A + B)	\$ _____
<b>GROSS AMOUNT REQUESTED:</b> (Net amount requested divided by 0.99)	\$ _____
DRF Amount (Gross amount requested x 1%)	\$ _____

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Authorized signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Please complete one request per Capital Bylaw, attach a certified copy of the adopted Capital Bylaw, as well as any amendments and the corresponding RHD Liability Certificate.**