

Regional Hospital Districts

REQUEST FOR LONG TERM FINANCING

1. Regional Hospital District: _____.

2. Capital Bylaw No.: _____.

3. Request is for MFA's debt issue in the Spring of 2_____.
Fall of 2_____.

4. Gross amount requested: \$ _____ (see reconciliation sheet)

5. Term requested: _____ years.

6. Authorized Signature _____.

Please print name & title _____.

Date _____.

**Please complete one form for each Capital Bylaw
Please attach copy of Capital Bylaw and the corresponding
Liability Certificate**

Reconciliation Sheet

(Please only use your share in these calculations)

Capital Bylaw Total: \$ _____

Less: Previous Portion converted to debenture
(If applicable) _____

Subtotal _____

Less: Interim Financing used to date
(If applicable) _____ (A)

Balance: _____ (B)

NET AMOUNT REQUESTED: \$ _____
(Can not be greater than A + B)

GROSS AMOUNT REQUESTED: \$ _____
(Net amount requested above divided by .9840)

For your information only:

DRF Amount
(Gross amount requested above x 1%) _____

Expenses
(Gross amount requested above x 0.60%) _____