

Sponsorship Application

Complete all information and submit at least 6 weeks prior to event. Incomplete applications will not be considered.

Name of Organization: _____

Contact Person: _____

Mailing Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Tax Status _____ Tax ID #: _____

Type of sponsorship requested: Monetary In-Kind

Amount you are requesting \$ _____

Have you received a monetary donation from this hospital in the past? Yes No

If so, how much and when? _____

OTHER DONATIONS

List your major contributors to this event/cause:

Are any other fundraisers planned (or have taken place this fiscal year)? Please list:

PURPOSE

What percentage of the money you raise goes toward administrative costs? _____%

Please classify your program below (select one)

Health & wellness Other (specify) _____

<u>Internal Use Only</u>
<i>Initial and Date</i>
Received: _____
Recommendation: _____
Approval: _____
Organization Notified: _____
Logo Sent: _____
Attendees: _____

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How many people will benefit **directly** from your efforts? _____

If this request is for a specific event, list the date(s) of the event _____

Are any Hospital employees actively involved in your organization? Yes No

If yes, please list their names and functions within your organizations

What is the primary focus of your organization?

If other local organizations provide the similar services, indicate how your program is unique.

How exactly will the funds you are applying for be used? (List local projects or economic benefits. Be specific.) _____

How will this project address local community needs?

How will you measure the success of your project?

I certify that the information above is correct and that the sponsorship, if approved, would be used solely as described above.

Signature: _____ Date: _____