Regional Health

SUBMIT FORM PRINT FORM

DONATION / SPONSORSHIP REQUEST FORM

Please email completed form, or print and send to:
Regional Health Community Relations
PO Box 6000, Rapid City, SD
info@regionalhealth.com

Date

Request is for: *(Please check one)*

☐ In-kind Services ☐ Monetary Donation ☐ Other (specify)_____

Name / Address of Organization

Person Submitting Request

Affiliation with Group

Purpose / Mission of Organization

Daytime Phone

Tax Status

☐ Not for Profit ☐ Govt / School
☐ For Profit ☐ Individual
☐ Other:_____

Requested Contribution *(Be specific – no open-ended requests)*

Date Contribution is Needed

Describe the event and/or use of funds and how many people will be impacted by donation/sponsorship

Recognition / Benefit Available to Regional Health

FOR OFFICE USE ONLY

☐ Approved Amount $ _____ ☐ Community Health ☐ Community Building

Account Number:____ ____ - ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

In-Kind Donation: _____

Check Request No./Date:_____ Date Sent: _____

APPROVAL

Signature: _____ Date: _____ Time: _____

☐ Declined

Date notification sent:_____

20160127