

# JENNIE STUART MEDICAL CENTER CONTRIBUTION REQUEST FORM

*So your request may be evaluated objectively, we ask that you please complete this form and return it by the first of the month. Thank you for your cooperation.*

*If your request involves an advertisement in a publication, please attach a copy of the publication or our previously placed ad, if available.*

DATE OF REQUEST: \_\_\_\_\_

ORGANIZATION NAME: \_\_\_\_\_

DOES ORGANIZATION HAVE 501(C) (3) STATUS?                      YES \_\_\_\_\_                      NO \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

NAME OF EVENT/PROJECT TO BE SPONSORED: \_\_\_\_\_

EVENT/PROJECT DATE: \_\_\_\_\_      TIME: \_\_\_\_\_      LOCATION: \_\_\_\_\_

DESCRIPTION AND PURPOSE OF ORGANIZATION OR PROJECT:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HISTORY OF EVENT/PROJECT ATTENDANCE & MONIES RAISED:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW WILL THE COMMUNITY BENEFIT FROM THIS EVENT/PROJECT?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AMOUNT OF CONTRIBUTION REQUESTED: \_\_\_\_\_

PURPOSE OF CONTRIBUTION: \_\_\_\_\_

DO YOU ANTICIPATE THIS BEING AN ANNUAL REQUEST?      YES \_\_\_\_\_ NO \_\_\_\_\_

WHAT IS JENNIE STUART MEDICAL CENTER EXPECTED TO PROVIDE?  
\_\_\_\_\_  
\_\_\_\_\_

WILL SPONSORSHIP SIGNAGE BE DISPLAYED?                      YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHERE WILL SUCH SIGNAGE BE DISPLAYED? \_\_\_\_\_

WHO WILL PROVIDE? \_\_\_\_\_

WILL JENNIE STUART MEDICAL CENTER BE INCLUDED ON ALL PRINTED MATERIALS, INCLUDING

PRINT ADS?

YES \_\_\_\_\_ NO \_\_\_\_\_

WHAT IS THE DEADLINE FOR SPONSORSHIPS? \_\_\_\_\_  
FOR SUBMISSION OF LOGOS/ARTWORK? \_\_\_\_\_  
FOR SUBMISSION OF DONATED ITEMS? \_\_\_\_\_

WILL JENNIE STUART MEDICAL CENTER RECEIVE EVENT/PROJECT TICKETS?

YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, GIVE QUANTITY AND ESTIMATED VALUE: \_\_\_\_\_

IF MONETARY SUPPORT IS UNAVAILABLE, COULD YOUR ORGANIZATION USE SPECIALTY ITEMS  
DONATED BY JENNIE STUART MEDICAL CENTER? YES \_\_\_\_\_ NO \_\_\_\_\_

RECORD OF PREVIOUS GIFTS BY JENNIE STUART MEDICAL CENTER:

<u>AMOUNT</u>	<u>YEAR</u>
_____	_____
_____	_____
_____	_____

RECORD OF CURRENT EVENT/PROJECT SPONSORS AND THEIR RESPECTIVE SUPPORT LEVELS:

<u>NAME</u>	<u>AMOUNT</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RECORD OF PREVIOUS YEARS EVENT/PROJECT SPONSORS, IF APPLICABLE:

<u>NAME</u>	<u>AMOUNT</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

***PLEASE INCLUDE ANY ADDITIONAL PERTINENT INFORMATION ALONG WITH THIS FORM UPON SUBMISSION.***

**PLEASE RETURN TO:**

N. LOUANNE YOUNG  
DIRECTOR, MARKETING AND COMMUNITY RELATIONS  
JENNIE STUART MEDICAL CENTER  
320 W. 18<sup>TH</sup> STREET  
P.O. BOX 2400  
HOPKINSVILLE, KY 42241-2400

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