FRANKLIN COUNTY
FCMC
MEDICAL CENTER

DONATION REQUEST FORM

ORGANIZATION INFORMATION

Name: _____

Mailing Address: _____

Contact Name: _____ Title/Position: _____

Email: _____ Phone Number: _____

Website: _____

Description of Organization: _____

_____

_____

_____

EVENT INFORMATION

Event: _____

Date: _____ Title/Position: _____

Description of Event: _____

_____

_____

_____

Number of Attendees: _____

Who will be served by this event? (projected audience, past attendees, demographics)

_____

_____

_____

_____

FCMC GIVING PRIORITIES

What FCMC giving priority does this event or organization align with:

▢ Health Education ▢ Promoting Health & Wellness ▢ Doing Good in the Local Community

How will this event improve healthcare in our region? _____

_____

_____

SPONSORSHIP

Amount Requested: _____ Date Needed: _____

Describe any available sponsorship level, associated benefits and exclusivity: _____

_____

_____

List any other sponsor and their sponsorship level: _____

_____

_____

What opportunities are available for FCMC to promote its services and capabilities? Include any opportunities for a FCMC representative to speak at the event. _____

_____

_____

Has FCMC donated to this event or organization in the past: ▢ YES ▢ NO

Please provide years and amounts of past donations: _____

_____

_____

How will FCMC be recognized as a sponsor of this event or organization?

▢ Announced at the event ▢ Logo placement online ▢ Logo on event materials

▢ Logo placement in other communications ▢ Print advertisement ▢ Booth at event

▢ Speaking opportunity at event ▢ Other: _____

SPONSORSHIP APPROVAL

(office use only)

▢ Approved ▢ Rejected

Comments: _____

_____

_____

Signed by:

_____

CEO/ CFO/ Administrator Date