TWIN COUNTY
Regional Healthcare
Duke LifePoint Healthcare

Sponsorship Application

Internal Use Only

Initial and Date

Received:_____

Recommendation:

_____

_____

CHNA Alignment? Yes / No

*Approval:*_____

Organization Notified:_____

Logo Sent: _____

Attendees: _____

_____

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) _____

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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: _____