St.Francis
EMORY HEALTHCARE

Sponsorship Application

Complete all information and submit at least 8 weeks prior to event.
Incomplete applications will not be considered.

Internal Use Only

Initial and Date

Received:_____

Recommendation:

_____

_____

*Approval:*_____

Organization Notified:_____

Logo Sent: _____

Attendees: _____

_____

Name of Organization: _____

Contact Person: _____

Mailing Address: _____

City/State/Zip: _____

Phone: _____ Email:_____

Tax Status _____ Tax ID #: _____

Type of sponsorship requested: ☐ Monetary ☐ In-Kind

Amount or in-kind donation you are requesting $ _____

_____

Have you received a monetary or in-kind donation from this hospital in the past?

☐ Yes ☐ No

If yes, how much and when? _____

OTHER DONATIONS

List a few of your other major contributors for this event/cause:

_____

Are any other fundraisers planned (or that 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 ☐ Children, youth & education ☐ Culture & humanities

☐ Civic Enhancement ☐ Other (specify) _____

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Signature: _____ Date: _____