

FUNDRAISING SPECIAL EVENT APPLICATION

1. SPONSOR INFORMATION:

Name of sponsoring organization/individual:						
Contact person:				_Title:		
Address:						
Home phone:	O	ffice phone:		_Fax:		
Best time to call:						
2. EVENT INFORMATIO	ON:					
Name of event:						
Description of event:						
Location(s) of event:						
Please attach estimate	d timeline					
Date(s) and time(s) of eve	ent:					
Date event will end:						
		- ·		re Foundation within 45 days of this date.)		
Method of raising funds,	including fees	s charged:				

Do you plan to pay an individual or organization to help plan, manage or conduct the event or to solicit contributions?

Name(s) of any organization(s) with whom you will have any contract or agreement in relation to the event:

Would you like a Community Hospice representative to attend you event, if possible?	Yes	No			
What time do they need to be present?					
Will you be advertising or publicizing this event? If so, who will be handling these tasks?					
Who is your target audience?:					
Please attach approvals by local authorities and evidence of insurance.					
3. USE OF FUNDS:					

Will this event benefit Community Hospice & Palliative Care exclusively?: _____

If not, please list other organizations that will benefit: _____

Do you have a specific area you would like proceeds to go to?

Yes, we would like the proceeds to go where Community Hospice & Palliative Care has the greatest need.

Yes, we would like the proceeds to go to Community PedsCare.

_____Yes, we would like the proceeds to go to the Charles M. Neviaser Educational Institute.

4. FINANCIAL INFORMATION

Please attach an estimated budget. Please estimate:

(Sponsor is not liable for amount listed.)

Total Proceeds:	А
Expenses (include costs such as printing, food, entertainment, equipment rental, promotions, etc.):	В
Anticipated net proceeds (A minus B):	C
Amount/percentage of net proceeds given to Community Hospice & Palliative Care Foundation:	D

Anticipated date of your donation:

5. SIGNATURE

Until written permission has been granted by Community Hospice & Palliative Care Foundation, contributions may not be solicited in the name of Community Hospice & Palliative Care Foundation and the names "Community Hospice & Palliative Care, Community Hospice & Palliative Care Foundation, Charles M. Neviaser Educational Institute and Community PedsCare" may not be used for any purpose.

Information provided on this form is correct and accurately describes the event/promotion.

Signature

Date

This form is due no later than six (6) weeks prior to the proposed event. Completion of this form does not assure approval. You will be contacted if further information is needed. Written response from Community Hospice & Palliative Care Foundation will be sent by mail.

If you have any questions regarding this form or your fundraising event/promotion, please contact the Donor Relations Officer at 904.407.6135.

Mail or fax application to:

Community Hospice & Palliative Care Foundation 4266 Sunbeam Road Jacksonville, FL 32257 904.886.3885 fax adavis@communityhospice.com