Black River MEMORIAL HOSPITAL

# DONATION APPPLICATION FORM

**Note: BRMH donates only to non-profit organizations**

Today's Date:_____

## CONTACT INFORMAITON

Contact Person:_____ Title:_____

Phone Number:_____ Email:_____

## ORGANIZATION INFORMATION

Legal Name of Organization:_____

Organization Contact Name (if different than above): _____

Address:_____

Website:_____ Is your organization a 501(c)(3)? ☐ YES ☐ No

## EVENT DETAILS

Official Name of the Event: _____

Date of the Event: _____Location of the Event: _____

What age group will most benefit from this donation? ☐ All ages ☐ Children ☐ Teens ☐ Adults ☐ Seniors

The number of individuals who will benefit from this donation?_____

Donation Requested: ☐ Monetary $_____ ☐ In-Kind _____

Date Needed by:_____

How will this donation impact the health of Jackson County?

If approved, the check should be made payable to:_____
(Donation information may be published on social media and submitted to local news agencies.)

Address where the check is to be sent (If different than above):

Please submit the form along with any supporting documentation you may have at least 45 days in advance by email to excellence@brmh.net or print and mail to/drop off at:

Black River Memorial Hospital
Attn: Community Development Specialist
711 West Adams Street
Black River Falls, WI 54615