

Charitable and Sponsorship Request

Instructions: Complete form and return with required attachments using the return options below.
 Requests will be reviewed monthly.

Date (Month DD, YYYY)	Organization	501(c)(3) (non profit) <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		
City	State	ZIP Code
Phone Number	Email	
Taxpayer Identification Number (attach copy)	If not a 501 (c)(3), provide your fiscal agent number (attach your or fiscal agent's W-9)	

Charitable Donation Request **Event or Sponsorship Request**

Amount Requested	Total Amount of Project/Sponsorship Level
Activity's Budget Plan (attach copy, if applicable). Briefly describe how contribution will be used and benefit the community.	
How many people will participate or be served by this program or event?	
How will sponsorship align with the following priority areas? Check all that apply and provide brief description.	
<input type="checkbox"/> Access to Care <input type="checkbox"/> Chronic Disease Prevention <input type="checkbox"/> Enhance Community Health <input type="checkbox"/> Obesity <input type="checkbox"/> Advance Medical Knowledge <input type="checkbox"/> Documented Community Need <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____	
Description:	
List other funding sources contributing to this service/program/event:	
What is the community impact if this service/program/event was <i>not</i> provided?	
How will you recognize Mayo Clinic Health System for this contribution?	

Requestor Information	
Name	Address
Phone	Email

RETURN	by MAIL	Mayo Clinic Health System ATTN: Public Affairs 1400 Bellinger St Eau Claire, WI 54703
	by EMAIL	Save completed PDF to your desktop and attach to an email, <i>along with required attachments</i> , to EUCOMMUNITYGIVING@mayo.edu.

PUBLIC AFFAIRS OFFICE USE ONLY

Date (Month DD, YYYY)	Sponsorship Amount	CO/PAU	Approved By
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