

# DONATION APPLICATION FORM

Note: BRMH does not donate to individuals or businesses.



Date: \_\_\_\_\_ Legal Name of Organization: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Address of Organization \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Website: \_\_\_\_\_ Email: \_\_\_\_\_

Dollar Amount Requested: \$ \_\_\_\_\_ Date Needed By: \_\_\_\_\_

In-Kind (Products or Equipment): \_\_\_\_\_

Please describe specific event associated with this request:

\_\_\_\_\_

Will this donation impact any of the following areas? (Check all that apply)

- Substance Misuse (drug, alcohol, tobacco)
- Behavioral/Mental Health (access to services)
- Chronic Disease Prevention and Management

What age group will most benefit from this donation?

- All ages       Infants/Children       Teens       Adults       Seniors

Which gender will most benefit from this donation?

- Females       Males       Both

Number of individuals who will benefit from this donation? \_\_\_\_\_

If approved, check should be made payable to: \_\_\_\_\_

Address where check is sent: (if different than above): \_\_\_\_\_

All donations will be published on social media and submitted to local news agencies.

### Please submit your donation request to:

Black River Memorial Hospital  
Attn: Marketing Director  
711 West Adams, Black River Falls, WI 54615

**OR**

Scan and submit to [excellence@brmh.net](mailto:excellence@brmh.net)

### For Office Use Only

Approved <input type="checkbox"/>	Not Approved <input type="checkbox"/>	Amount or Equipment Value	
Date		Authorizing Employee	
GL:	520-8850-00		
CBISA Reportable YES <input type="checkbox"/> NO <input type="checkbox"/>	Restriction Letter <input type="checkbox"/>	Submitted to Finance <input type="checkbox"/>	