DONATION APPLICATION FORM

Note: BRMH does not donate to individuals or businesses.

Black River MEMORIAL HOSPITAL

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

For Office Use Only			
Approved ☐	Not Approved ☐	Amount or Equipment Value	
Date		Authorizing Employee	
GL:	520-8600-00		
CBISA Reportable YES ☐ NO ☐		Restriction Letter ☐	Submitted to Finance ☐