REV. 3/4/2019

SSM HEALTH CARDINAL GLENNON CHILDREN'S FOUNDATION

In-Kind Donation Form

This gift is: ☐ **from a single individual or organization** ☐ **the result of a collection or fundraising event** *(Please complete reverse side)*

DONOR INFORMATION

If donor is an individual please fill out **Section A**. *If donor is an organization please fill out* **Section B**.

Section A: Individual Information:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: ____________ Marital Status: ☐ Single ☐ Married ☐ Widowed

First Name: ____________ M.I. ___ Last Name: ____________

Suffix: ______ Birthdate: ____________

Address: ____________ City, State, Zip: ____________

Preferred Phone: ____________ Preferred Email: ____________

Spouse Name: (if applicable) ____________ Spouse Birthdate: ____________

☐ I have personally experienced the exceptional care provided by SSM Health Cardinal Glennon Children's Hospital.

☐ A member of my family has experienced the exceptional care provided by SSM Health Cardinal Glennon Children's Hospital.

Section B: Organization Information:

Organization Name: ____________

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: ____________

Contact Name: ____________ Position: ____________

Address: ____________ City, State, Zip: ____________

Preferred Phone: ____________ Preferred Email: ____________

DONATION INFORMATION

ALL DATA IN THIS SECTION MUST BE COMPLETED BY THE DONOR.

What prompted donation: ____________ Donation Date: ____________

In-Kind Donation: ☐ Donated Goods ☐ Donated Professional Services

Est. Fair Market Value: ____________ Gift is Anonymous: ☐ Yes ☐ No

Description of Item(s) Donated: ____________

____

____

____

TRIBUTE INFORMATION

Honor/Memorial Information: *Complete this section if donation is being made in Honor or Memory of someone.*

Tribute Name: ____________ ☐ In Honor ☐ In Memory

FOR INTERNAL USE ONLY

Appeal Name: ____________ Package Name: ____________ Classy Page ID: ____________

How was the gift used: ☐ Auction Item ☐ Give Away/Swag ☐ Transfer to Hospital ☐ Other day-of fundraising (Raffle, sale, etc.)

Were benefits provided? ☐ Yes ☐ No Value of benefits received: $____________

Description of benefits received: ____________

Tax Receipts Approved by Dev Services (date and initials) ____________

Special Instructions: ____________

Cash Donation Revenue Total: ____________ (please fill out monetary form)

Staff Accepting Gift: ____________ **Date:** ____________

FUNDRAISER HOST INFORMATION

If event is hosted by an individual please fill out **Section A***. If event is hosted by an organization please fill out* **Section B***.*

Section A: Individual Information:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: ____________________ Marital Status: ☐ Single ☐ Married ☐ Widowed

First Name: ________________________________ M.I. ___ Last Name: ____

Suffix: _________ Birthdate: _______________________________

Address: ____ City, State, Zip: ___________________________

Preferred Phone: ___________________________ Preferred Email: ____

Spouse Name: (if applicable) ____ Spouse Birthdate: __________________

☐ I have personally experienced the exceptional care provided by SSM Health Cardinal Glennon Children's Hospital

☐ A member of my family has experienced the exceptional care provided by SSM Health Cardinal Glennon Children's Hospital.

Section B: Organization Information:

Organization Name: ____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: ____________________

Contact Name: ____ Position: __________________________________

Address: ____ City, State, Zip: ___________________________

Preferred Phone: ___________________________ Preferred Email: ____

FUNDRAISER EVENT INFORMATION

Name of Event: ____ Type of Event: ___________________

Date of Event: _______________ Location of Event: ________________________________ Cost of Participation: ________

Did you host an online donation page in conjunction to your event? ☐ Yes - Page Name: ______________________________
☐ No

Summary of Event: ____

____

What prompted this event? ____

DONATION INFORMATION

In-Kind Donation: ☐ Donated Goods ☐ Donated Professional Services

Donation Date: _______________ Est. Fair Market Value: _____________________________ Gift is Anonymous: ☐ Yes ☐ No

Description of Item(s) Donated: ____

____

____

FUNDRAISER TRIBUTE INFORMATION

Honor/Memorial Information: ***Complete this section if donation is being made in Honor or Memory of someone.***

Tribute Name: ____ ☐ In Honor ☐ In Memory

FOR INTERNAL USE ONLY

Appeal Name: ________________________ Package Name: _______________ Classy Page ID: ____________________________

How was the gift used: ☐ Auction Item ☐ Give Away/Swag ☐ Transfer to Hospital ☐ Other day-of fundraising (Raffle, sale, etc.)

Were benefits provided? ☐ Yes ☐ No Value of benefits received: $____

Description of benefits received: ____

Tax Receipts Approved by Dev Services (date and initials) ____

Special Instructions: ____

Revenue Total: ____

Staff Accepting Gift: ____ **Date:** ___________________________