



Sponsorship & Charitable Donations Request Form

NOTE: All requests must be submitted on this form to the Marketing & Communications Department a minimum of 12 weeks prior to date needed. **Please fill out this form completely.** This is required in order for request to be processed. *Additionally, all requests must have supporting documentation attached with information on the event, purpose, sponsorship levels, etc.*

MAIL TO: Hattiesburg Clinic, Marketing & Communications | 415 S. 28th Avenue, Hattiesburg, MS 39401
FAX TO: (601) 261-3601 **OR** **EMAIL TO:** publicrelations@hattiesburgclinic.com

DATE: _____ **IS YOUR ORGANIZATION A 501(C) 3:** Yes No
DATE RESPONSE IS NEEDED FOR SPONSORSHIP RECOGNITION: _____ (must be 12 weeks from date turned in)
ORGANIZATION NAME: _____

HAS HATTIESBURG CLINIC SPONSORED THIS EVENT IN THE PAST? Yes No **If yes, when:** _____

TYPE OF ORGANIZATION: For-Profit Business Non-profit

WEBSITE: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

FEDERAL TAX ID NUMBER (or Social Security Number, if individual): _____

*The Federal Tax ID number or SSN is needed if a monetary donation is requested so the organization or individual may be entered into the Hattiesburg Clinic vendor system and a check issued. **A W-9 needs to accompany this request.***

REQUEST MADE BY: _____

PHONE: _____

E-MAIL: _____

Hattiesburg Clinic is committed to supporting initiatives that support health, education and community development. Please indicate what initiative this project/event supports and describe how this project/event provides opportunities for the clinic to support the community.

PLEASE CHECK WHICH INITIATIVE THIS REQUEST WOULD FALL UNDER:

Health Education Economic/Community Development

SUPPORT REQUESTED:

Sponsorship Charitable Contribution Ad Sponsorship (attach all info) Novelty Items

If monetary, please specify amount requested: _____

Please continue on back.

Information on the event or request must be attached in order to be processed. All event/project documentation should also be attached.

EVENT NAME:

WHAT IS THE PURPOSE OF THE EVENT?

DATE: _____ TIME: _____ LOCATION: _____

ESTIMATED ATTENDANCE: _____ LAST YEAR'S ATTENDANCE: _____

PRIMARY AGE GROUP OF ATTENDEES: _____

WILL HATTIESBURG CLINIC BE ACKNOWLEDGED AS A CONTRIBUTOR/SPONSOR? IF SO, HOW?

Contact person will be notified as to whether or not the sponsorship is approved and at what level.

CONTACT NAME:

CONTACT PHONE: _____ CONTACT EMAIL: _____

CHECK PAYABLE TO: _____

CHECK MAILING ADDRESS: _____

Please attach all supporting documents.

A photo or other proof of advertisement must be submitted, along with an evaluation, (which can be found on www.hattiesburgclinic.com) to publicrelations@hattiesburgclinic.com after the event to be considered for future sponsorships/donations.

SEND PROOF OF ADVERTISEMENT AND THIS APPLICATION TO:

MAIL TO: Hattiesburg Clinic, Marketing & Communications – 415 S. 28th Avenue – Hattiesburg, MS 39401

FAX TO: 601-261-3601 Email to: publicrelations@hattiesburgclinic.com

For more information, call 601-268-5606.

Office Use Only

DATE RECEIVED: _____ APPROVED: _____ DECLINED: _____

REASON: _____

LEVEL OF PARTICIPATION:

Check requested Door Prize Given Ad Submitted

Other _____

CONTACT PERSON NOTIFIED: (DATE) _____ (BY): _____