# CHILDREN'S SPECIALIZED HOSPITAL– 2025 IN-KIND DONATION FORM

*Thank you for thinking of the patients at Children's Specialized Hospital. Your kindness is appreciated!*

## PART 1 OF 2 – ALL INFORMATION REQUIRED, PLEASE PRINT LEGIBLY

| DONATION ITEM DESCRIPTION | NUMBER OF ITEMS | DONOR ESTIMATED VALUE ($) REQUIRED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

* Continue on back if necessary I certify that this is my best estimate (DONOR SIGNATURE) _____

## PART 2 OF 2: DONOR/CORPORATION/COMMUNITY GROUP INFORMATION (REQUIRED)

**Name:** _____

**Group Name *:**_____

**Address:** _____**Phone:** _____

**City, State, Zip**_____**Email:**_____

## *CORP/COMMUNITY GROUPS - ADDITIONAL INFO REQUESTED:

**Project Description:** _____

**Number of group members participants? (***If applicable***) ***_____**# of hours per participant**_____

** These hours are recorded as donated hours and it is important info for us.*

***For Internal Use Only*:**

**IMPORTANT: Security Personnel** – Please call Volunteer Dept.: NB/MTN Vivian X55536, Kenna X55415 or in TR Deidre X 51112 to see if they are available to accept donation. If not fill out all of the info in detail.

**CSH EMPLOYEE: *PLEASE FILL IN AREA BELOW***

**Received by (CSH Employee Name):** _____ **CSH Location/Ext:** _____

**Date received:** _____

******* IMPORTANT: Please send this form to- Vol MTN within 2 days of receiving items*******

CUT HERE

## THIS IS YOUR RECEIPT (TO BE FILLED OUT BY THE DONOR)

Donor Name: _____

Item Description: _____ Donor Provided Value $_____

Received by (CSH Staff): _____CSH Location _____Date:_____

****** No goods or services were given/received in exchange for this donation. ******

**Children's Specialized Hospital Foundation IRS Code 501(c) 3 charity -Tax ID 13-6844298**