

CHILDREN'S SPECIALIZED HOSPITAL– 2026 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