



IN-KIND DONATION FORM

ALL information required for our Foundation Department. Please print legibly.

Please have donor **fill in an estimated value** so that the item can be counted as a donation

<u>Item Description</u>	<u>Number of Items</u>	<u>\$ VALUE*</u>
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***This information is required by our Auditors. Please make your best guess if not known.**

A) INDIVIDUAL DONOR(S) – Please complete

All information required. (Please fill in so that the gift can be acknowledged-Info is never shared)

Name: _____

Address: _____

Phone #: (_____) _____

E-mail Address: _____

OR

B) ORGANIZATION/COMMUNITY GROUP – Please complete

All information required. (Please fill in so that the gift can be acknowledged-Info is never shared)

Group Name: _____

Contact Person: _____

Address: _____

Phone Number: () _____

E-mail Address: _____

Describe Your Community Project (If applicable): _____

How many group members participated in this project? (If applicable) * _____

How many estimated hours total did this project take? (If applicable) * _____

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

***Thank you for thinking of the patients at Children's Specialized Hospital. ***

Your kindness is appreciated! ☺

For Internal Use Only: **Date Received:** _____

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

CSH EMPLOYEE: PLEASE FILL IN AREA BELOW SO IF THERE ARE QUESTIONS WE CAN CONTACT YOU

Received by (CSH Employee Name): _____ **CSH Location/Ext:** _____ (2/23)