

HOSPITAL

Community Health Improvement Program

Application for In Kind Medical Supplies Support

Name of Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Position: _____

Phone Number: _____ Fax: _____ E-mail: _____

Please attach a brief overview of the organization and an explanation of how the supplies will be utilized. A copy of the organization's IRS documentation of current tax-exempt status should also be included. Questions should be directed to Jill McAllister, Community Health Improvement at 260-373-7982. The completed application should be delivered to Parkview Hospital Foundation as follows:

By Mail: 2200 Randallia Drive **By Hand:** 2120 Carew St. **By Fax:** 260-373- 7976
Fort Wayne, IN 46805 Fort Wayne, IN

Funding criteria:

- The recipient organization must be a not-for-profit organization and provide services without discrimination.
- The completed application must be submitted a minimum of **30 days** prior to the date the medical supplies are needed.
- There is a **\$500 annual limit** per organization.
- A status report is required within 90 days following distribution of the medical supplies.
- Part of the agreement in receiving the donation is that appropriate recognition and acknowledgment is provided to Parkview through the media and the organization's own publications. Parkview may attempt to publicize the contribution in various news media in which activities of Parkview Hospital, Parkview Hospital Foundation, or Parkview Health are highlighted.

Signature

Title

Date

Printed Name

Parkview Hospital's mission is to provide quality health services to all who entrust their care to us and we will work to improve the health of our communities.