DONATION REQUEST FORM

750 West D Avenue
Kingman, Kansas 67068
foundation@kingmanhc.com

Organization/Event/Group:_____ **Today's Date:**_____

Contact Person: _____ **Title:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone Number: _____ **Email Address:** _____

What services are rendered by your organization/group? _____

_____

What percentage of the donation will be used to help with health and wellness services/needs/functions/education/growth/ opportunities in Kingman County and surrounding areas? _____ **How will these funds be used?**_____

_____

Please include any other information you would like for the KHCF to know_____

_____

_____

_____

_____

Will the Kingman Healthcare Center Foundation be listed on any materials or social media in recognition for your event/ need? Yes____ No____ If yes, please email foundation@kingmanhc.com so our logo can be sent to you.

By what date do you need the contribution?_____

How much of a contribution are you seeking? $_____

To whom should the check be made payable? _____

Signature: _____ **Date:** _____

Return form via email to: foundation@kingmanhc.com
or by mail: Kingman Healthcare Center Foundation
750 West D Avenue
Kingman, Kansas 67068

KHCF Use Only

Date Received: _____ Date of Review:_____ Approved:_____ Denied:_____ Initials:_____

Comments:_____
_____
_____