Community Event / Sponsorship Request Form

Section 1: Information about the person completing this form.

Your name (and title, if appropriate):					
Organization (and department, if applicable):					
Address:					
City:		State:		Zip Code:	
Phone Number:		Fax Number:			
Email Address:					

Section 2: Information about the sponsorship opportunity or event.

Name of organization requesting sponsorship:					
Name of sponsorship opportunity or event:					
Location of event:	City:		State:		
Event date(s):					

Briefly describe opportunity or event:

Briefly describe why PCMH should sponsor your event:

Total cost of sponsorship (i.e. amount requested):	$		
Has PCMH sponsored this event/organization in the past? :	Yes	No	Don't Know
Please include any additional information that may assist in the evaluation of this sponsorship request:	# Number of people served by this event _____		

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Section 3: Please submit your request as indicated below.

Attach this completed request form to a written, original copy of the proposal or request for sponsorship (on letterhead/stationary) and send to:

Perry County Memorial Hospital
Administration
8885 State Road 237
Tell City, IN 47586
Fax: (812) 548-0248

Please contact Administration at (812) 547-0170 with additional questions.
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For Internal Use Only:

Does the sponsorship opportunity or event meet one or more of the following?

Health/Fitness/Wellness & Health Promotion Issues

Recognized Community Health

Disease Prevention Services

Access to Health Care

Amount Requested:	$	Approved	Denied
Amount Approved:	$		
Account GL #			
Comments:			
Approved By:		Date:	