PROVIDENCE
HEALTHCARE FOUNDATION

Third Party Intake Form

Name of Individual/Group/Organization: _____

Name of Contact person(s) responsible for the event: _____

Mailing address: _____

City: _____ Province: _____ Postal Code: _____

Primary telephone: _____ Business telephone: _____

E-mail: _____

Do you have a connection to Providence Healthcare Foundation? If so, please describe:

FUNDRAISER INFORMATION

Fundraiser Name (as you would like to be recognized): _____

Type of Fundraiser: _____

Direct Funds to ☐ Area of Greatest Need ☐ Other: _____

By submitting this application, I am requesting that Providence Healthcare Foundation approve the fundraiser.

I understand that if approved, I will receive a copy of Providence Healthcare Foundation Fundraising Guidelines, which I will be required to sign and which will be binding.

These Guidelines include the following:

- Use of Providence Healthcare Foundation name and logo in event publicity and materials.
- Providence Healthcare Foundation support of the event organizer(s).
- Net revenues from the fundraiser to be received by Providence Healthcare Foundation within 30 days of the event.
- Fundraiser financial summary to be submitted showing all revenues and expenses.
- Charitable tax receipts issued in accordance with Canada Revenue Agency (CRA) regulations.

Please note that Providence Healthcare Foundationn adheres to the requirements of the Federal privacy legislation (PIPEDA) and expects the fundraising event organizer(s) and associated volunteers to do so as well.

Signature of Applicant(s): _____

_____

_____

Today's Date: _____

EVENT APPROVAL

Signature of Providence Healthcare Foundation official: _____

Today's Date: _____