MAYO CLINIC HEALTH SYSTEM

Charitable and Sponsorship Request Form
Public Affairs

Albert Lea and Austin | ☐ Albert Lea ☐ Austin

Instructions: Please complete form and return to Public Affairs, 1000 First Drive N.W., Austin, MN 55912. Please note, requests over $1,000 require committee approval and will be reviewed every other month.

Organization Information

Date (Month DD, YYYY)	Requester Name		
Street Address	City	State	ZIP Code
Phone Number	Email Address		
Organization/group requesting donation		501C 3 *(non profit)* ☐ Yes ☐ No	
Please note: No donations will be contributed directly to booster clubs that provide scholarships to graduating seniors.			

☐ **Charitable Donation Request**
(Individual requests exceeding $9000 will not be considered in any one year)

☐ **Event or Sponsorship Request**

☐ List previous requests and years funded _____ _____	☐ Have not previously requested
Amount requested*	Total Amount of Project / Sponsorship Level

Brief description about how contribution will be used / Sponsorship will benefit community
_____
_____
_____

How many people will participate/be served by this program or event?

Activity's Budget Plan *(Please attach. If sponsorship, please include info about how funds will be used)*
_____

Please provide a brief description about how monies/sponsorship requested fit into one or more of the identified priority areas:

Improving Family Outcomes	*Health-Related Organizations*	*Community Health Education*
Promoting Youth Potential	*Community Partner*	*Community Health Needs Assessment Implementation*

_____
_____

Please list other funding sources contributing to this service/program/event

What is the community impact of not providing this service/program/event?
_____
_____

How will you recognize the medical center for this contribution?
_____
_____

Please attach additional pages if needed   rev0414