

SPONSORSHIP REQUEST APPLICATION

Today's Date _____

1. All requests must be made by completing this form and attaching your flyer, brochure, or request on letterhead.
2. **Requests must be made at least three months prior to date needed.**
3. **All requests are reviewed by the Sponsorship Oversight Committee. The committee determines whether Dignity Health of the Central Coast will sponsor you or your organization.**
4. Send Request Application to Sara San Juan, Communications Specialist, at: sara.sanjuan@dignityhealth.org or at 1400 E. Church St., Santa Maria, CA 93454; 805.739.3574.

Name of Organization or Group Requesting Sponsorship: _____

Address _____

City/State/Zip _____

Taxpayer ID number _____

Contact Person _____ Telephone # _____

E-mail address _____

Include the following:

- 1) Check payable to _____
- 2) Mailing address _____
- 3) If applicable - Print ad specs (size and format) _____

Donation Requested \$ _____

Date the Check is needed _____

Purpose of Request (What will a donation help you accomplish?) attach additional pages if necessary.

**Please note that while all sponsorships are considered and all are worthy, those which align with our mission to help provide access to care or which promotes health and wellbeing in the communities we serve will be given greater consideration. **

Has your organization received sponsorship from Arroyo Grande Community Hospital, French Hospital Medical Center or Marian Regional Medical Center in the past? ____ If so, when? for what and for how much? _____

Please attach your flyer, brochure, or letter advertising your event