Dignity Health

Arroyo Grande Community Hospital
French Hospital Medical Center
Marian Regional Medical Center

SPONSORSHIP REQUEST APPLICATION

Today's date: _____

1. All requests must include this form *in addition to your flyer, brochure, or request on letterhead*.
2. **Requests must be made <u>at least three months prior to date needed</u>**.
3. All requests are reviewed by the Sponsorship Oversight Committee.
4. Email the completed request to: DignityHealthCentralCoastCommunications@dignityhealth.org.

Name of organization requesting sponsorship: _____
(This is the name that will appear on the check unless otherwise noted)

Address: _____
(This is the address the check will be mailed to unless otherwise noted)

City/State/Zip: _____

Taxpayer ID number: _____ (please include W-9)

Contact person: _____

Telephone # _____ E-mail address _____

Amount requested $_____ Date check is needed _____

Print ad size and format, if applicable _____

Purpose of request: (What does the sponsorship support?) Attach additional pages if necessary.

_____

_____

_____

Please note, while supportive in spirit of all approaches that encourage positive community improvements, we are limited to providing financial support to projects most closely aligned with our core mission and values.

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? _____