COMMUNITY HEALTHCARE FUNDING REQUEST

To be completed by requesting person or organization and sent to Olds Healthcare Fundraising Committee

Requesting Organization:

Date of request:

Contact Name & Title:

Contact Phone Number:

Description of the event / program:

Cost: Rough Estimate Actual Quote

Minor Equipment <$5000 Capital Equipment >$5000

Requesting Organization/Dept. Manager or Director Approval Name:

Signature: Date:

To be completed by Committee

Committee Comments:			
Date reviewed by Foundation:			
Approved by Foundation	Yes	No	Date:
Requesting Organization notified:	Yes	No	Date:
Fund released/reimbursed:	Yes	No	Date:
Thank You Note sent to Foundation by receiving Org.:	Yes	No	Date:

Last updated Jan 2025

Email: info.oldshfc@gmail.com

If more space is required please use back of sheet