Community Fundraising Registration Form

The Hospital of Central Connecticut
Department of Philanthropy
100 Grand Street, New Britain, CT 06050
HOCCdevelopment@hhchealth.org

We gratefully acknowledge your interest in hosting a fundraising activity to benefit The Hospital of Central Connecticut. Please take the time to complete this form in its entirety and return to us by email. For additional information, please call (860) 224-5567.

Date of Application: ___/___/___ Primary Contact: ___________________________

Name of Person, Company or Organization:______________________________________

Address: ____

City: _________________________________ State: ___________ Zip Code: ___________

Phone:___________________________________Fax:________________________________

Email: ____

Event Name:____

Brief Description of Event (feel free to attach activity description documentation if appropriate):____

____

____

Event Date(s) & Times (s):____

Scheduled Rain Date(s) (if appropriate):____

Location(s):____

Projected Attendance:____

Is the event open to the public: ❑ Yes ❑ No

Has this event been done before?: ❑ Yes ❑ No

Sponsors, if any:____

____

Would you like to donate to the area(s) of greatest need:________________________

If not, what specific area would you like the funds to go to: _____________________

Additional Information

Admission Fee:____

Estimated Donation:____

Please make check payable to: **The Hospital of Central Connecticut***
and mail to:

The Hospital of Central Connecticut
Department of Philanthropy
100 Grand Street
New Britain, CT 06050

Please indicate the name of the event on the check in the memo section.

For planning and acknowledgment purposes, please provide the best estimate as to the date of distribution of activity funds to be submitted to **The Hospital of Central Connecticut**: ____/_____/_____

***All funds are required to be submitted to The Hospital of Central Connecticut within 45 days of the activity**

I have read and agree to abide by the Community Fundraising Guidelines as set forth herein by The Hospital of Central Connecticut's Department of Philanthropy.

Host Representative Signature: ____

Printed Name: ____

Title: ____ Date: ___/___/___

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For office use only: ❑ **Approved** ❑ **Declined**

If No, reason?____

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Staff Signature:____ Date: ___/___/___