COMMUNITY MEDICAL CENTER

From day one.

Your health – our commitment to you, from day one.

Community Benefit Request Form

Date of Application: _____ Request: ☐ Funding $_____ ☐ In-Kind

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Name/title of contact person: _____

Organization's Mission/Vision Statement:

_____

_____

Event/Project Name: _____

Event/Project Dates: _____

Event/Project Duration: _____

How does your request compliment one of the following core services and CMC's mission?

☐ Oncology _____

☐ Pediatrics _____

☐ Women's and Infant

☐ Rehabilitation _____

How will this event/project improve the health of residents in our region?

_____

_____

Will there be recognition opportunities related to this donation?

_____

_____

Specify how the funds will be spent: _____

Describe past support received from Community Medical Center:

_____

_____

If this request is approved, I understand that I may be asked to provide Community Medical Center with a follow-up report detailing how many people were impacted and how our contribution was used.

Signed: _____ Date: _____

Our Community Benefit committee gathers the first Thursday of each month.
Please send in an application to cmcsponsorship@communitymed.org or mail to Marketing, 2827 Fort Missoula Rd, Missoula, MT 59804. Fax 327-4501.