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.