MEMORIAL MEDICAL CENTER FOUNDATION
MEMORIALCARE® HEALTH SYSTEM

MMCF Staff Use _____

"CHARITY OF CHOICE"
Event/Fundraising Questionnaire

Memorial Medical Center Foundation supporting Long Beach Memorial, Miller Children's & Women's Hospital Long Beach and Community Hospital Long Beach, is a not-for-profit organization governed by a Board of Trustees. The Board has established a policy that allows third party fundraisers to choose Long Beach Memorial, Miller Children's & Women's Hospital Long Beach and/or Community Hospital Long Beach as their **Charity of Choice**. In these instances, there is no use of the Foundation's 501(c)(3). Information requested must be furnished before approval can be given to use the name of Long Beach Memorial Medical, Miller Children's & Women's Hospital Long Beach and/or Community Hospital Long Beach for an event or fundraiser. Please complete this questionnaire and return it as soon as possible. Memorial Medical Center Foundation will notify you within 30 days on the status of your request.

NAME OF ORGANIZATION: _____

CONTACT: _____ TITLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

EMAIL: _____

NAME OF EVENT/PROJECT: _____

DATE AND LOCATION OF EVENT/PROJECT: _____

_____

DESCRIPTION OF EVENT/PROJECT: _____

_____

HOW WILL THE EVENT/PROJECT RAISE MONEY? _____

_____

FUNDS RAISED PREVIOUSLY THROUGH THIS EVENT/PROJECT:

$_____ DATE _____ $_____ DATE _____

RESPONSIBILITIES OF YOUR ORGANIZATION: _____

_____

_____

WHY DID YOU CHOOSE LBMMC/MCH/CHLB AS THE BENEFICIARY OF YOUR EVENT?

_____

_____

PROPOSED BUDGET

Identify sources of income: ticket sales, entry fees, item sales, etc.

SOURCE	QTY	PRICE	TOTAL INCOME

TOTAL ESTIMATED INCOME $_____

Identify expenses: printing, postage, food, facilities, etc.

ITEM	QTY	PRICE	TOTAL COST

TOTAL ESTIMATED EXPENSES: $_____

ANTICIPATED GROSS INCOME: $_____ EXPENSES: $_____

EXPLANATION OF EXPENSES: _____

_____

_____

ANTICIPATED PROCEEDS TO BENEFIT LBMMC/MCH/CHLB: $_____

ANTICIPATED PROCEEDS TO BENEFIT YOUR ORGANIZATION: $_____

ANTICIPATED PROCEEDS TO BENEFIT OTHER CHARITIES: $_____

NAME OF OTHER CHARITIES: _____

_____

MMCF can expect the check presentation date to be:_____

Please identify any businesses you wish to contact, so that we may coordinate our efforts. (Use a separate sheet if necessary.) *Memorial Medical Center Foundation requests this in writing prior to soliciting of any businesses.*

DOES EVENT NEED TO BE CLEARED BY THE LOCAL AND STATE AUTHORITIES? _____ YES_____ NO

IF INSURANCE IS NEEDED, PLEASE NAME MMCF AS ADDITIONAL INSURED. ***Memorial Medical Center Foundation will need a copy.***

I HAVE READ AND AGREE TO ABIDE BY THE SPECIAL EVENT/FUNDRAISING POLICIES:

_____ _____

SIGNATURE DATE

_____

TITLE

Please mail. email or fax to: Memorial Medical Center Foundation,
LBMMCFoundation@memorialcare.org, 2801 Atlantic Ave., Long Beach, CA 90801, Phone *(562)933-GIVE, Fax (562)933-3652 Attention Charity of Choice*