

Staff only
Date received: _____ Location received: _____
Received by: _____ Department: _____ Ext: _____

Donor information
Would donor like to receive a receipt for tax purposes? Yes No
Individual(s): _____
 Mr. Mrs. Ms. Dr. Miss
Organization: _____
Contact person: _____
Address: _____
City: _____ State: _____ Zip: _____
Email address: _____ Cell phone: _____
Home phone: _____ Business phone: _____
Donor is a: Volunteer Patient family Employee Other: _____

Donation (Please explain clearly)
Note: All donation of equipment or artwork for permanent display must have hospital approval prior to acceptance

Description of item(s):	Quantity
_____	_____
_____	_____

Estimated value (according to donor): \$ _____
Volunteer hours spent on project: _____
Number of volunteers: _____

Monetary donation amount: _____ Cash Check #

Would donor like to receive information for Children's Health in the future? Yes No