DONATION REQUEST FORM

The following information is required for Neighborhood Pharmacy to consider your request.

Organization:	D	ate:	
Organization's Contact Person:		Title:	
Mailing Address:	City:	State:	ZIP:
Phone Number:	Email Address:		
 Please ensure your proposal includes the following i A description of your organization, including its A copy of the letter from the IRS stating your org A list of key staff and titles and current Board of 	mission and major accompanization's 501(c)(3) stat	us, if applicable.	
Contact person's relationship to the organization:			
Employee Volunteer_	Paid Work	er Fund Rai	ser
What services are rendered by your organization?			
What percentage of the donation will be used to help und	derserved women, children	n, seniors, the homeless, an	d LGBTQ+?
How will this donation be used?			
Which other financial institutions have you approached fo What type of contribution are you seeking? (Check		lease list	
Monetary \$(pleas	se be specific)		
Neighborhood Pharmacy Promotions			
Desired Items:			
By what date do you need the contribution?			may not be considered.
Does your organization do business with Neighborhood I	Pharmacy?		
To whom should the check be made payable?			
Signature of Organization's Officer: Within 30 days following the event, ple			∍d.
Req. Number: Date of Review: Approved: De	enied: Conditions:		

Internal Use Only