Community Donations
Request Form

Today's date: ____________ Date donation needed: ____________

Please allow 2 - 3 weeks turnaround time.

Name of organization: ____________

(This will be listed as the payee on the check if your request is approved)

Contact person: ____________

Phone number: ____________ Contact email: ____________

Organization's Address: ____________

City: ____________ State: ____________ Zip: ____________

(This is where the check will be mailed if your check is approved)

Is this a tax exempt organization and/or activity? Yes ☐ No ☐

If yes, 501(c)3 #: ____________

Note: If you are a 501(c)(3) tax exempt organization, you must provide your IRS determination letter.

Please describe your organization & mission.

____

____

Type of donation needed:

Service ☐ Financial ☐ Materials ☐ Other ☐

Dollar amount requested: ____________

(An amount is required, we cannot accept open-ended requests)

What will this donation be used for? ____________

____

Who will benefit from this donation? ____________

____

How will Confluence Health be recognized for this donation? ____________

____

What other funding sources are you seeking? ____________

____

Is this request from a Confluence Health employee, or is an employee affiliated with the organization? Yes ☐ No ☐

If Yes, name of employee: ____________

Did Confluence Health contribute to your organization last year? Yes ☐ No ☐

If Yes, what were the funds specifically used for? ____________

____

Please return the completed form to:

Confluence Health | Moses Lake Clinic
Attn: Amanda Brixey, Administrative Assistant | 840 E. Hill Ave. | Moses Lake, WA 98837 Phone: 509.764.6400 | Email: amanda.brixey@confluencehealth.org | Fax: 509.764.6480