



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 | Omak Clinic

Attn: Sandra Zaragoza, Administrative Assistant | 916 Koala Drive | Omak, WA 98841

Phone: 509.826.1800 | Email: sandra.zaragoza@confluencehealth.org | Fax: 509.826.7913