



GROWING SMILES PEDIATRIC DENTISTRY :: DONATION REQUEST FORM

DONATION REQUEST INFORMATION

Today's Date: _____

Name: _____

Name of Organization: _____

Email Address: _____

Tax Exempt #: _____

Telephone #: _____

Fax #: _____

Street Address: _____

City, State, Zip: _____

ORGANIZATION INFORMATION

This organization is:

- Educational or Scholastic-Related
- Non-Profit/Charitable [Must include 501(c) documentation]
- Community Organization
- KU Organization (i.e., fraternity, sorority, student government, etc.)
- Fundraising for a local benefit for sick, injured or disabled individual
- Other: _____

NOTE: Information (i.e., flyer, brochure, etc.) describing the event must be included/attached to this completed form

- Please explain the reason this donation is being requested:

- Proceeds from the event/project will be used for:

- Approximately how many individuals will benefit from this donation? _____
- Donation Amount Requested: \$ _____
- Date Donation is Needed: _____

ADDITIONAL COMMENTS:

OFFICE ONLY:

- CURRENT PATIENT? Yes/No
- APPROVED (Check sent/date _____)
- DENIED

INITIALS: _____ DATE: _____