Community Fundraising Event Application Form

Name of Event: ___________________________________ Date and Time: ________________________________

Event Location/Address: ____________________________________________________________________________

Name of Group/Company Planning Event: ____________________________________________________________________________

Name of Individual Responsible: __________________________ Email address: _________________________

Mailing Address: ___________________________________________________________________________________

Primary Phone: ( ) ____________ Business Phone: ( ) ____________ Fax: ( ) ____________

On page 2, describe the event and how funds will be raised; e.g., ticket sales, pledges, sponsorships, raffle, etc.

How will the event be publicized (e.g. press releases, flyers, radio/TV, printed ads, social media)? Albany Medical Center must review and approve all promotional materials before they are used.

______________________________________________________

Is event: □ Open to the public □ By invitation only Ticket price (if applicable): $__________

Has this event taken place before? □ Yes □ No
If so, when _____/_____/____ and what was net income of last event held? $ ________________

Are there other beneficiaries besides Albany Medical Center? □ Yes □ No
If yes, please list the beneficiaries and explain how the proceeds will be divided.

______________________________________________________

Does this event qualify for corporate gift match? □ Yes □ No
(For more information visit: http://www.matchinggifts.com/amc/)

Will this gift be restricted to a specific area or program within Albany Med? □ Yes □ No
If yes, please list the area or program:

______________________________________________________

Will expenses be: □ Taken out of proceeds? □ Paid by event organizer?

Using page 2, please list all businesses you plan to solicit for cash or in-kind (products or services) support.

Please indicate quantities of supplies needed:
Children's Hospital Balloons ______ Children's Hospital Banners ______ Informational Brochures____
Please indicate quantity next to each item, and attach any additional notes or requests.

Anticipated donation to Albany Medical Center $__________ Date funds should be received: ______________

□ I have read and agree to adhere to the Albany Medical Center Community Events Fundraising Policy WEB ADDRESS (or call 518.262.3322 to request a copy)
□ I understand certain gaming events (e.g. raffles, bingo) require a license and it is my responsibility to secure this. More information is available at www.racing.state.ny.us or (518) 453-8460.

_________________________ ____________________________ ____________
Signature Name (please print) Date
Event description:

____________________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________________

How funds will be raised:

☐ Ticket sales  ☐ Pledges  ☐ Sponsorships  ☐ Drawing  ☐ Other (please describe below)

____________________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________________

Businesses to be solicited:

<table>
<thead>
<tr>
<th>Name of Business</th>
<th>Address</th>
<th>Cash/In-kind (products or services)</th>
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Additional notes or requests:

__________________________________________________________________________________________

Please submit this completed form to:

Albany Medical Center Foundation, Attn: Community Events, 43 New Scotland Avenue MC-119
Albany, New York 12208, Fax (518) 262-4769, Development@mail.amc.edu
# Community Fundraising Event Application Form

## Projected Revenue and Expense Sheet

<table>
<thead>
<tr>
<th>Source of Revenue (sponsorship, ticket sales, etc.)</th>
<th>Details (company name, number of tickets sold, etc.)</th>
<th>Amount</th>
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<th>Expense (company name or payee)</th>
<th>Details (description of expense)</th>
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Please Note:
- Event organizers may not keep any portion of the proceeds as profit or compensation for organizing the event.
- The estimated cost per dollar raised should be 50 cents or less.
- Should the event expenses exceed the total collected, your organization is responsible for payment of additional expenses.

Projected Net Income/Donation (total revenue-expenses) = _________________________________________________________________

Additional notes:
__________________________________________________________________________________________________________________________________________

Please submit this completed form to:
Albany Medical Center Foundation, Attn: Community Events, 43 New Scotland Avenue MC-119 Albany, New York 12208, Fax (518) 262-4769, Development@mail.amc.edu
Approval:_____________________________ Date:____________________