

THIRD PARTY EVENT Proposal Form



EVENT CONTACT INFORMATION:

Name of Person, Group or Company Planning Event: _____

Contact Person: _____ Event Name: _____ Event Date: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Email: _____ Date Submitted: _____

EVENT DETAILS:

Tell us about your event and how funds will be raised:

- Funds raised from your event will be directed to the area of the hospital where the need is greatest, unless otherwise specified:
- Is this event in honour or memory of someone special? Yes No
- If yes, please list name and contact information. For memorials, please provide contact information of next of kin or family contact.
- How do you plan to promote the event/activity (posters, newsletter, radio, print, TV)?
- Will your event be open to the public? Yes No
- Has this event taken place before? Yes No
- If yes, how much did the event raise the last time it was held?
- What portion of the Net Event proceeds will you be donating to the Foundation? %
- Is this a "One-Time" or "Annual" event?

Proposed Budget

All costs for your event must be paid by the organizer or be taken from the event proceeds.

Event Terms and Conditions

By signing this application, I agree to:

- 1. Allow the Stevenson Memorial Hospital Foundation to promote the event and use the event logo and/or images.
- 2. Submit all communications / promotional material to the Stevenson Memorial Hospital Foundation for approval prior to use.
- 3. Submit all proceeds to the Stevenson Memorial Hospital foundation within 30 days of the event date.
- 4. Provide a statement of revenue and expenses within 60 days of the event date.

To help make your event a success, the Stevenson Memorial Hospital Foundation commits to:

1. Offer our help and event planning expertise.
2. Have volunteers or staff attend the event or cheque presentation, when and if available.
3. Provide Foundation materials for your event such as brochures, donations boxes where needed.
4. Promote your event among hospital staff, on our website and social media.

Third Party Community Fundraising Event Agreement:

This is a Third Party fundraiser agreement between Stevenson Memorial Hospital Foundation and _____
(3rd Party Name)

Name of Third Party Primary Contact:

Signature*: _____ Date: _____

Name of Stevenson Memorial Hospital Foundation Representative:

Signature: _____ Date: _____

**An electronic signature is sufficient if forms are sent via email.*

Please submit forms by email, fax, mail or in person to:

Stevenson Memorial Hospital Foundation
200 Fletcher Crescent
PO Box 4000
Alliston Ontario
L9R 1W7

Phone 705-435-6281 x 1262
Fax 705-434-5116
foundation@smhosp.on.ca



For Stevenson Memorial Hospital Foundation Use Only

Approved by: _____ Date: _____