THIRD PARTY FUNDRAISING EVENT APPLICATION

Contact Information:

Organization:_____

Contact Person:_____

Please check which category best describes your organization:

□ Community □ Corporate □ School □ Service Club □ Other:_____

Address: _____

City:_____Prov:_____Postal Code:_____

Phone:_____E-Mail:_____

Event Information:

Has this event taken place before? □ Yes □ No

If so, when? _____

Proposed Event Plan:

Type of Event: _____

Event Date: _____

Location:_____

Target Audience: _____

Additional Details (raffles, promotional ideas etc.): _____

_____

Thank you for your interest in raising funds in support of patient care at Michael Garron Hospital. We will be in touch to further discuss the details of your event and how we can help you along the way.

Please submit this form to:

Brittany Caines, Special Events Assistant
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Tel: 416-469-6580 ext. 2098
Brittany.Caines@tehn.ca