



Third Party Fundraiser Form

The following form is an application only.
Upon submission you will receive notification of fundraiser approval or denial.

Name of Group/Organization: _____

Address: _____

City, State, Zip : _____

Contact Person: _____

Title: _____ Phone Number: _____

Fax Number: _____ Email: _____

Do you have a previous connection with All Children's Hospital? If so, please describe: _____

Fundraiser Name: _____

Date(s) of Fundraiser: _____ Time(s): _____

Name and Address of Facility where fundraiser is being held: _____

Website: _____

How will the dollars be raised: _____

How will the funds be collected: _____

What percentage of raised funds go to ACH: _____

What other organizations receive funding if ACH receives less than 100% of funds: _____

Is this fundraiser part of the ACH Foundation's Children's Miracle Network Hospitals program? Yes or No

Does the applicant have a Certificate of Insurance to cover the Fundraiser? Yes or No Carrier:

_____ Policy Number: _____ Type of

assistance requested from ACH: _____

Are you requesting use of the hospital logo: Yes or No

If Yes, please explain your use of the logo: _____

Please list the sponsors you plan to solicit for fundraiser support (This information is required so we can avoid conflicts with sponsors and donors who many already be involved with other fundraising efforts.) _____

Would you like your fundraiser listed on the events portion of the ACH Foundation website? Yes or No

If Yes, please list contact name and number and/or email/website: _____

Please indicate the types of promotions you plan to do for your fundraiser: _____

Press Release Flyers TV Print Ads Invitations Social Media Email Invite Web

In the event that All Children's Hospital or Foundation name is used in any print or electronic media promotion, we ask that you provide us with a copy of any press releases and resulting articles. We also ask to be notified of any media events or appearances and radio and television spots.

Who is providing food/drink: _____

Is alcohol being sold or given away: Yes or No

Do you have a liquor license: Yes or No

Who is responsible for providing security: _____

Name of Security Company: _____

Is the security company licensed: Yes or No Insured: Yes or No

Is the Fundraiser a Trade Show or Health Fair: Yes or No

If Yes, how many trade/vendor booths: _____

Are there other goods sold or displayed: Yes or No

If Yes, describe goods: _____

All Children's Hospital, Inc. is the owner of all right, title and interest in All Children's Hospital and design marks. All Children's Hospital, Inc. grants Licensee a non-exclusive right to use these marks in promotions for only the event listed above through and including the date of the event. Licensee shall only promote the fundraiser listed above in a manner authorized by All Children's Hospital, Inc. Licensee shall not modify, alter or amend the marks. Licensee shall acquire no right, title or interest in these marks by virtue of the license permitting the Licensee to use the marks in promotions only for the event listed above. All uses of the marks by Licensee shall inure to the benefit of All Children's Hospital, Inc. Licensee agrees not to challenge or otherwise interfere with the validity of the marks of All Children's Hospital, Inc.'s ownership of the marks.

Please note that funds raised on the behalf of All Children's Hospital and its entities should be sent to the hospital Foundation within 60 calendar days of the fundraiser date.

Please sign: _____

Please indicate date 60 calendar days from your fundraiser date: _____

Please return signed form to:

Special Event Coordinator
All Children's Hospital Foundation
PO Box 3142
St. Petersburg, FL 33731-3142

Phone Number: (727) 767-4332

Fax Number: (727) 767-8510

Website: <http://www.givetoallkids.org>