FUNDRAISING FORM

For groups who wish to fundraise for
Sydney Local Health District facilities

NAME: _____
(of person/s wishing to fundraise)

ORGANISATION: _____
(if applicable)

ADDRESS: _____

_____

TELEPHONE: _____

MOBILE: _____

Fascimile: _____

E-mail: _____

TYPE OF FUNDRAISING ACTIVITY PROPOSED
(Activities requiring authorisation include raffles, fetes, dinners, donation boxes, direct mail, art unions etc.)

_____

_____

_____

PLEASE STATE MAIN OBJECTIVES OF FUNDRAISING ACTIVITY AND LIST IN FULL DETAIL. FOR EXAMPLE, TO FUND SPECIFIC PROJECT OR PURCHASE, RAISE PROFILE OF SERVICE / DEPARTMENT, GAIN SUPPORT BY CREATING STRONG LINK WITH LOCAL COMMUNITY, HEALTH PROMOTION

Objective 1: _____

Objective 2: _____

Objective 3: _____

Objective 4: _____

Other – please specify:

_____

_____

_____

DETAILS OF FUNDRAISING ACTIVITY
Please supply full details. For example, for a raffle: a list of prizes, retail value, where prizes come from, selling of tickets – selling price, where & when, when the raffle will be drawn. For more details refer to Raffle Application Form).

Date & Time: _____

Location: _____

Estimated Income: _____

Estimated costs: _____

Details: _____

_____

_____

Please note that gross expenditure is not to exceed 40% of gross income.

It is an auditing requirement that all fundraising requests have attached supporting documentation of a pre-event budget work up, providing proposed expenses and revenue. A final reconciliation of income and expenditure is to be provided at the conclusion of the event.
Please refer to attached example of income and expenditure template.

Fundraising proceeds to be donated to: (Name of hospital and specific department)

_____

_____

I have received a copy of the responsibilities of fundraisers for Sydney Local Health District and I agree to conduct all fundraising activities in conjunction with these guidelines.

Name of person co-ordinating event: _____

Signature:_____ **Date:** _____

Please return completed form for Chief Executive Officer's signature to:

Marketing & Community Relations Department (Bldg 8A)
Concord Hospital
Hospital Road
Concord NSW 2139

Note: A copy of this signed form will be returned to you for your records

AUTHORISATION

Signed: _____ **Date:** _____

HEAD OF DEPARTMENT

Signed: _____ Date: _____

GENERAL MANAGER

Signed: _____ Date: _____

CHIEF EXECUTIVE OFFICER

If you require further information, please contact the Marketing & Community Relations Department on 9767 6038