



UNYIELDING DETERMINATION. EMPOWERING LIVES.

Community Partner Event Approval Form

Thank you for your interest in supporting Craig Hospital. Filling out this application will allow us to help you develop the best event possible. Please allow 30 days for processing and review. Return completed form to Caroline Craven at Craig Hospital, 3425 S. Clarkson St., Englewood, CO 80113, ccraven@craighospital.org.

Have you reviewed the [Community Partner Event Guidelines](#)?

Name of Event _____ Date of Event _____

Time of Event _____ Location of Event _____

Contact Information

Name _____ Title _____

Company/Organization _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____ Fax _____

Please select the category that best describes you:

- Individual Business School Community/Social Club Service Club Other

If "Other," please describe _____

Event Overview

Why do you want to support Craig Hospital? _____

Please provide a brief description of your fundraising event. _____

Will the funds be Unrestricted ___ yes ___ no If no, please list the fund or department you wish to benefit: _____

Event Logistics (please check yes or no and provide additional information

Will alcoholic beverages be served? Yes No

If yes, do you have a permit to serve alcohol? Yes No

Is insurance required for this event? Yes No

Have you obtained insurance? Yes No

If yes, please indicate Property Liability List the name of the insurance company _____

Please check with Craig Hospital to determine whether we need to be listed as an additional insured.

Have you obtained the proper permits and licenses that pertain to your event? Please list the permits you have acquired and the permits you are still working on. _____

How often will the event occur? One time Annual On-going Other If other, please explain:

How long have you put on these benefits? First year _____ # of years _____

Will this event benefit another organization? yes no Provide name: _____

Will this event have a planning committee? yes no Provide names _____

Revenue / Budget (If you have a budget for the promotion, please send us a copy. If not, please estimate.)

Anticipated Revenue \$ _____

Percentage of net proceeds to be donated to Craig Hospital? _____% If less than 100%, please list the amount and explain: _____

Marketing / Promotions

Are there sponsors tied to the event (i.e. corporate, media partners, etc.)? yes no If yes, please list:

Will you need to use the Craig Hospital Foundation Community Partner logo? yes no How will you utilize logo?

(Printed materials which include the name/logo of the hospital must be reviewed and approved to ensure that it is consistent with our graphic standards)

Public Outreach – please check all that apply

Public Relations Advertising Radio Website TV Print Outdoor Flyers Other _____

Craig Hospital Involvement

Do you require assistance from Craig Hospital Foundation staff? yes no If so, in what capacity? _____

We will be in contact with you after your application has been submitted.