CHAPTERS
HEALTH® SYSTEM

GOOD SHEPHERD HOSPICE • LIFEPATH HOSPICE
HPH HOSPICE • HPH HOME HEALTH • PALLIATIVE CARE

Community Event Application

Thank you for your interest in hosting an event to benefit Chapters Health Systems. Because of the potential liability with outside events, we ask that each organization complete the following application. Once the application is completed and approved, we will follow up with you and provide educational and marketing materials.

Please complete the application below and return it to:
Chapters Health System
Attention: Development Department
12470 N. Telecom Drive, Suite 300, Tampa, FL 33637
Phone: (813) 871-8111 Fax: (813) 871-8473
development@chaptershealth.org
www.chaptershealth.org

Again, thank you for your interest in supporting Chapters Health System and the patients we serve.

Date _____

Name of person responsible for event:_____

Address:_____

City: _____ State:_____ Zip:_____

Telephone: _____ E-Mail:_____

Name of organization/ company:_____

Main point of contact:_____

Organization/ company address:_____

State:_____ Zip:_____ Telephone: _____

Other phone *(if applicable)*:_____ Email Address:_____

Do you have a logo that can be included on our Web site? ❒ Yes ❒ No
Will you include the Chapters Health System logo on your Web site? ❒ Yes ❒ No

Can you provide photographs that can be used for publicity? ❒ Yes ❒ No

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Do you need a Chapters Health System banner? ❒ Yes ❒ No
If so, please list available space _____

When is the banner needed? _____

Do you plan to provide fliers for this event? ❒ Yes ❒ No

Do you plan to issue press releases? ❒ Yes ❒ No

Can Chapters Health System provide press releases? ❒ Yes ❒ No

Have you hosted this event for Chapters Health System before? ❒ Yes ❒ No

Describe the proposed event:_____
_____
_____
_____
_____

Date and time of proposed event: _____

Any permits or permissions required for event? ❒ Yes ❒ No

If yes, please describe_____
_____

What, if any, support will be required from Chapters Health System?
_____

Would you like a Chapters Health System representative at the event? _____

Estimated income from event $_____

Estimated number of attendees_____

Estimated expenses$_____

Estimated net donation to Chapters Health System $_____

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What are the expenses (please list) _____
_____

Who will pay these expenses?_____

What is the attendance price of this event if any? _____

Is this event being held in memory of someone? ❒ Yes ❒ No
If so, who?_____

If the net donation is more than $1,000, would you like to be contacted concerning our Tree of Life Memorial Program to honor your loved one? ❒ Yes ❒ No

The Development Department of Chapters Health System solicits a number of businesses in the community for donations for our Annual Events. It has become extremely difficult to monitor volunteers asking for donations outside of our approved annual events and we can no longer allow your proposed event/fund raiser to solicit any organization on behalf of Chapters Health System without permission from Chapters Health System. This includes retail stores, business, companies and restaurants. Thank you for your understanding.

Do you have plans in place to thank donors? _____

Will you provide Chapters Health System with a list of participants so that we can send a thank you note?
_____

I agree to abide by all requirements made by Chapters Health System.

Signed:_____ Date:_____
(Name)

Please wait and do not proceed with your event until this form has been signed by a Chapters Health System representative. Thank you.

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The mission of Chapters Health System is to provide quality palliative care and relieve the suffering of those in our communities affected by life-limiting illnesses and end-of-life issues, maintaining the highest ethical standards, so all may live as fully and comfortable as possible.

For Hospice Internal Office Use, not to be filled out by applicant.

Event Approved by: _____ *Date approved:* _____
Primary Staff person assigned to event: _____