Event Application Form

Application must be approved by the Medicine Hat & District Health Foundation prior to promoting or hosting your event.

Your Information

Name of Group

Primary Contact

Mailing Address

City

Phone

Email

Role

Postal Code

Alternate Phone

Briefly describe the event and how funds will be raised.

How many people do you expect to attend the event?

What is your expected revenue for the event?

Event Information

Name of Event

Start Date

Start Time

Name of Venue

Location of Venue

End Date

End Time

Are you planning on hosting a raffle? YES NO

Do you understand and agree that you are responsible for obtaining all insurance and/or licences required for the proposed event? YES NO

Do you understand and agree that all event costs are to be covered by the event organizer? YES NO

Will the Medicine Hat & District Health Foundation be the sole beneficiary of the event? YES NO

Does the event organizer agree that the Medicine Hat & District Health Foundation will receive all revenues from the event within 60 days of the event end date? YES NO

Do you understand and agree that all promotional materials for the proposed event must be approved by the Medicine Hat & District Health Foundation prior to being released? YES NO

Do you understand and agree that the Medicine Hat & District Health Foundation will not assume any financial or legal liability along with any damages that may incur at the event. YES NO

Event Application Form (Cont.)

Please indicate if you require the following for the proposed event (requires three weeks notice).

- O Endorsement letter
- O Print materials about the Medicine Hat & District Health Foundation
- O A member of the Medicine Hat & District Health Foundation to speak at your event
- O Volunteers

Please indicate either the fund or area you would like the raised funds designated to:

- O Greatest Needs
- O Children's Health
- O Women's Health
- O Men's Health
- O Senior's Health
- O Mental Health
- O New Tech
- O Other

Please complete, sign and submit the application electronically.

Applicant Signature

Print Name

Date

Area/Department

Medicine Hat & District Health Foundation
Donor Relations Coordinator
666 5 Street SW
Medicine Hat, AB T1A 4H6
P 403 528 8133 F 403 502 8649
E health.foundation@ahs.ca

Visit myhealthfoundation.ca for more information.

Thank you! Our Annual Giving Coordinator will contact you upon receiving your application.

Submit Form