



## Community Fundraising Registration Form

MidState Medical Center  
Department of Philanthropy  
435 Lewis Avenue, Meriden CT 06451  
[midstatedevelopment@hhchealth.org](mailto:midstatedevelopment@hhchealth.org)

We gratefully acknowledge your interest in hosting a fundraising activity to benefit MidState Medical Center. Please take the time to complete this form in its entirety and return to us by email. For additional information, please call (860) 224-5567.

Date of Application: \_\_\_/\_\_\_/\_\_\_ Primary Contact: \_\_\_\_\_

Name of Person, Company or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Event Name: \_\_\_\_\_

Brief Description of Event (feel free to attach activity description documentation if appropriate): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Event Date(s) & Times (s): \_\_\_\_\_

Scheduled Rain Date(s) (if appropriate): \_\_\_\_\_

Location(s): \_\_\_\_\_

Projected Attendance: \_\_\_\_\_

Is the event open to the public:  Yes  No

Has this event been done before?:  Yes  No

Sponsors, if any: \_\_\_\_\_

Would you like to donate to the area(s) of greatest need: \_\_\_\_\_

If not, what specific area would you like the fund to go to: \_\_\_\_\_

**Additional Information**

Admission Fee: \_\_\_\_\_

Estimated Donation: \_\_\_\_\_

Please make check payable to: **MidState Medical Center\***  
and mail to:

MidState Medical Center  
Department of Philanthropy  
435 Lewis Avenue  
Meriden, CT 06451

*Indicate the name of the event on the check in the memo section.*

For planning and acknowledgment purposes, please provide the best estimate as to the date of distribution of activity funds to be submitted to MidState Medical Center: \_\_\_/\_\_\_/\_\_\_

**\*All funds are required to be submitted to MidState Medical Center within 45 days of the activity.**

I have read and agree to abide by the Community Fundraising Guidelines as set forth herein by MidState Medical Center’s Department of Philanthropy.

Host Representative Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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**For office use only:**     **Approved**         **Declined**

If No, reason? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_