

THIRD PARTY FUND RAISING REQUEST APPROVAL FORM

100% NET PROCEEDS FOR BENEFIT OF SHRINERS HOSPITALS FOR CHILDREN

(Attach this form to sponsor's mission statement or use my Email address: <mailto:apasmas@shrinernet.org>)

Or fax to: (813) 281-8460

Request submitted by: _____

Title: _____

Representing: _____ Shriners Hospitals or
_____ Shrine Temple

Request date: _____ Event Coordinator (s) _____

Corporate Sponsor's name (if applicable): _____

Coordinator (s) mailing address: _____

Coordinator (s) phone number (s): Office: _____ Fax: _____

E-mail address (if available): _____

Type of event: _____ Event date (s): _____

Event location: _____

Imperial Council's approval date: _____ State solicitation filing verified by: _____

Date event was closed on: _____ Total amount donated: \$ _____

NOTE: Copy of donation check is to be sent to Director of Temple Accounting or fax to (813) 281-8460

FYI: Shriners Hospitals for Children bylaws Section 503.10 state "the use of the name Shriners Hospitals for Children or reference to the Hospitals in connection with any commercial product or business enterprise is prohibited unless the written consent of the boards of directors and trustees has been first obtained.