



Host Information

Organization Name (if applicable): _____

Contact person: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____

About Your Event

Proposed Event Name: _____

Date/Time of Event: _____ Rain Date/Time: _____

Location: _____

Event website (if applicable): _____

To Benefit: AngelsGrace Hospice Cancer Heart Care Other _____

Expected # of participants: _____ Is this event: By invitation only Open to the public

Event Description: _____

Why did you choose ProHealth Care as a beneficiary of your event? _____

Funding and Donation Information

Are there beneficiaries other than ProHealth? Yes No If so, who? _____

Estimated: Revenue: \$ _____ Expenses: \$ _____ Proceeds: \$ _____

What activities will you be conducting to raise funds for ProHealth? (Admission, raffles, bingo, auctions, sales, etc.): _____

Do you plan to seek sponsorships from local corporations or foundations? Yes No

If so, who? _____

ProHealth's Roles and Responsibilities

I would like ProHealth's help with the following (please check all that apply):

- ProHealth's logo for use in our promo materials
- List my event information on ProHealthCare.org/Foundation
- ProHealth speaker at the event (subject to availability)
- Check presentation at the event or post-event
- ProHealth promotional and/or educational materials
- ProHealth Foundation donation envelopes

Terms of Agreement

By signing this document, you agree that you have read and understand ProHealth Care's Third Party Event Policy and agree to abide by it.

Signature of Event Organizer

Date

Printed Name

Your completed application can be mailed or emailed to:

Nicole Bessert
ProHealth Care Foundation
725 American Ave.
Waukesha, WI 53188
Nicole.Bessert@phci.org

If you have questions about the policy or application, please contact
Nicole Bessert | 262-928-4639 | Nicole.Bessert@phci.org