DONATION REQUEST FORM

All requests must be made at least 30 days prior to date needed

Completed forms must be mailed to:
Gateway Pharmacy
PO Box 994
Bismarck, ND 58504

Please complete all fields:

Name of Organization _____

Name and Date of Event _____

Contact Person _____ Phone _____

Mailing Address _____

_____

Reason for Donation Request (please be specific) _____

_____

_____

Amount of Item Requested: _____
Date Needed: _____

Tax ID # of Organization _____

Type of Organization _____

(please indicate if a 501C-3: not-for-profit)

Who does this Contribution benefit? _____

_____

How do you plan to promote our company with this donation? _____
_____

For office use only

Date received *staff member*