

Community Volunteer Event Registration Form

Please complete the following form so the Children’s Hospital Foundation of Manitoba (CHFM) can support your fundraising initiative while ensuring that the Foundation’s status, logo and reputation are protected.

Is your event hosted by?

a workplace a school a community group an individual

Contact Information:

Contact name or organizer: _____

Workplace or community group name (if applicable): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Phone: _____

Website: _____

Event Information:

Briefly describe your fundraising event: _____

Event Name: _____ Date: _____

Location: _____ Time: _____

If possible, would you like to have someone from CHFM attend your event? Yes No

If yes, what role will they play? _____

Is this an annual event? Yes No Maybe

Has this event taken place before? Yes No

Is the event open to the public? Yes No

Expected number of participants: _____



Publicity Information:

Are you planning on promoting the event to the public? Yes No

Briefly describe how the event will be publicized: _____

Will you be seeking approval to use the CHFM name and/or logo in any of your promotional materials?

Yes No

Do expect to involve the media? Yes No

PLEASE ENSURE THAT ALL PROMOTIONAL MATERIALS BEARING THE CHFM NAME AND/OR LOGO ARE SENT TO THE FOUNDATION FOR APPROVAL IN ADVANCE OF PRINTING OR DISPLAY.

Fundraising/Financial Information

CHFM understands that it's difficult to predict revenue. Please indicate your fundraising goals to the best of your ability.

Total donation of CHF: \$ _____

Total expected revenue: \$ _____

How do you plan to raise funds (ticket sales, donations, pledges)? _____

Are there any other charities benefiting financially from this event? Yes No

If yes, which charities? _____

If yes, what percentage of the total charitable amount will CHFM receive? _____%

Will tax receipts be requested for event participants? Yes No

Please remember that tax receipts are NOT guaranteed; we must first establish whether the funds donated are eligible for receipts. To do so, the Foundation requires a breakdown of how funds were raised and what benefits were received by event participants. The Foundation requires all donor names, amounts donated, full addresses and phone numbers or email addresses. For more information please receive the Charitable Tax Receipt Guidelines on the Canada Revenue Agency website at cra-arc.gc.ca.

Date CHFM can expect to receive net revenue: _____

AGREEMENT FOR COMMUNITY EVENT OR FUNDRAISING INITIATIVE BENEFITING THE CHILDREN’S HOSPITAL FOUNDATION OF MANITOBA

_____, the event organizer, agrees to organize and implement a special event/program on _____, to benefit the Children’s Hospital Foundation of Manitoba. The special event/program shall be described and publicly referred to as follows:

_____.

The event organizer agrees to use only the authorized name of Children’s Hospital Foundation of Manitoba in any media or printed materials relating to the special event/program (if name is to be used).

No cost or liability associated with this event shall be incurred by the Children’s Hospital Foundation of Manitoba.

Children’s Hospital Foundation of Manitoba agrees to provide the event organizer with recognition appropriate to the level of giving as set forth in our Donor Recognition Policy.

The event organizer agrees to handle any monetary transactions and to present the proceeds to the Children’s Hospital Foundation of Manitoba by the agreed upon date.

The event organizer will obtain all necessary permits, licenses or insurance.

The event organizer agrees to follow Children’s Hospital Foundation of Manitoba’s receipting policies that adhere to the Canada Customs and Revenue Agency.

The Children’s Hospital Foundation of Manitoba reserves at any time the right to withdraw the use of its name.

If the event is cancelled, the event organizer will notify the Children’s Hospital Foundation of Manitoba prior to the original event day.

Signed: _____

Date: _____

Event Organizer

Signed: _____

Date: _____

CHFM Representative