



**Medina Hospital
Foundation**



**In-Kind Contributions
Donation Form**

The undersigned agrees to donate the item(s) described herein to Cleveland Clinic Medina Hospital Foundation, a 501 (c) 3 charitable organization.

Donor Information - (Please Print):

Name: _____
Last First

Address: _____
Street City State Zip Country

Email: _____ Phone: _____

Description of Items Donated:

Retail or Fair Market Value

_____	\$ _____
_____	\$ _____
_____	\$ _____

*** Please attach copies of receipts or documentation for in-kind items contributed.**

Restrictions (if any apply): _____

Delivery / Pick-Up Arrangements: _____

Medina Hospital Contact Name / Department _____

I authorize Cleveland Clinic to advertise the items, if offered for purchase at a fundraising auction or raffle, on behalf of Cleveland Clinic Medina Hospital. Unless otherwise indicated, the Clinic may use my name in connection with this donation.

(☐) Please do NOT use my name in association with this contribution.

Signature: _____ Date: _____

☐ I wish for my/our name(s) to be recognized - listed in Cleveland Clinic Medina Hospital publications as:

☐ I wish to give anonymously

☐ I wish to designate my gift in honor/memory of: _____

Please complete this form and return by mail to:

Medina Hospital Foundation
Attn: Linda Kern, 1000 E. Washington St
Medina, OH 44256

You may also email the completed form and documentation directly to the Medina Hospital Foundation at
MH-Foundation@ccf.org

For Cleveland Clinic Internal Use Only

In-Kind Items received by:

Employee Name: _____ Department: _____ Date Received: _____