

# IN KIND DONATION FORM

*Information will not be shared outside of the medical center.*

Please Print

Donor \_\_\_\_\_

Company/Organization Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email Address \_\_\_\_\_

Donor's Estimated Value of Donation \$ \_\_\_\_\_ (required for processing)

Description of Donation (please be specific) \_\_\_\_\_

Donor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for Donation \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(CCHMC Employee)

**Please bring your in kind donation to:**  
Cincinnati Children's Hospital Medical Center  
Location B Welcome Center  
3333 Burnet Avenue  
Cincinnati, OH 45220

**Phone: 513-636-0918**  
**Fax: 513-636-7173**  
[www.cincinnatichildrens.org](http://www.cincinnatichildrens.org)

**Thank you for your generosity!**

change the outcome®

Revised May 14, 2008

