



IN KIND DONATION FORM

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 ____/____/____

* If you value your gift at \$5,000 or more, it is the donor's responsibility to obtain a qualified appraisal in order to substantiate a possible charitable deduction for tax purposes.

**You can also mail your
in kind donation to:**

Cincinnati Children's Hospital
Department of Development, MLC 9002
3333 Burnet Avenue
Cincinnati, OH 45229

**For more information,
please contact:**

Sara Coyle
sara.coyle@cchmc.org
phone: 513-636-8760
fax: 513-636-7173
www.cincinnatichildrens.org

Thank you for your generosity!