GIFT-IN-KIND DONATION FORM

Please provide us a few details regarding your gift:

Business Name: ____

Contact Name: ____

Mailing Address:
____
____
____

Daytime Phone: ____________________ Email Address: _________________________________

I'd like to be recognized as: ____

Donation Date and Time: __________________

Facility Being Donated To (Riverside Regional Medical Center, Walter Reed Hospital, Doctors' Hospital Williamsburg, Tappahannock Hospital, Shore Memorial Hospital, etc.): ________________________________

Donation description: ____
____
____
____

If at all possible, please attach a listing/invoice of inventory and the amount it cost, with the total reading zero (noting that nothing was owed and it was provided in-kind).

Retail Value: $__________________

Thank you for making a difference in the life and health of your community.
Riverside Health System is a 501c3 not-for-profit healthcare organization.
Your donation is deductible to the extent of Federal & State laws.

Updated March 2020