



Danville Regional

MEDICAL CENTER

Our Mission

Making Communities Healthier®

Our Vision

We want to create places where:

- People choose to come for healthcare,
- Physicians want to practice, and
- Employees want to work.

2017 Sponsorship & Donation Guidelines

Danville Regional Medical Center (DRMC) proudly supports a broad spectrum of health and community related causes which support programs and initiatives aimed at improving the overall health and well-being of our community.

Key Objectives

Our charitable donation and sponsorship activities are focused on two key objectives:

- Health
- Education of Health/Wellness Initiatives

Based on our key objectives, we have developed criteria for donations and activity/event sponsorship. Our criteria stems from a desire to fulfill our mission of Making Communities Healthier®; and in helping the citizens of our community access appropriate care, stay healthy and build healthy communities.

Donation Criteria

We will consider requests for donations from non-profit organizations that meet one or more of the following criteria:

- Activity has a direct or implicit connection with the listed key objectives

- Activity provides opportunities for the promotion or presentation of DRMC’s strategic initiatives

Activity/Event Sponsorship Criteria

We are also committed to partnering with non-profit organizations on activities or events focused on improving the health and wellness of those living in our community through increased awareness and education. Our partnerships foster good will in the community and promote our brand. A suitable sponsorship is one that is mutually beneficial for DRMC and the community we serve.

You may qualify for a sponsorship if your organization’s program meets the following criteria:

- Sponsorship has a direct or implicit connection with the listed key objectives
- Activity provides opportunities for the promotion or presentation of DRMC’s strategic initiatives

Policy and Procedures Concerning Donations and Sponsorships

The objective of these guidelines on donation and sponsorship request is to ensure the equitable distribution of approved funds with a view to investing in our community. Danville Regional Medical Center reviews sponsorship and donation requests based on the nature of the activity and on the organization’s philosophy, allocation criteria and available budget.

Screening Criteria

In order to evaluate the many requests that we receive that may fall within our guidelines, we have established criteria that will provide us with the pertinent information we need. Please complete the attached application (in its entirety) and submit to:

Danville Regional Medical Center
Attn: LeAnne Roller, Sponsorship/Donation Request
142 Main South Street | Danville, VA 24541
Or email: leanne.roller@lpnt.net

Note:

- Organizations seeking sponsorship or donation must make formal request by submitting a completed application. Only completed applications will be reviewed. Incomplete applications will be returned and may delay funding consideration.
- Organizations seeking funding for the 2017 calendar year must submit a completed application no later than January 31, 2017.
- An organization whose request for sponsorship or donation is approved will be notified no later than February 28, 2017.
- An organization may receive only one donation or sponsorship per calendar year.
- An organization whose request for sponsorship or donation is approved will be required to submit a “Post-Event Outcomes” form, within 15 days of the event.



Danville Regional

MEDICAL CENTER
DukeMedicine QUALITY AFFILIATE

Donation and Sponsorship Application

For internal completion only:

Date received _____ Date of program/project _____
Target _____ In-kind Financial \$ _____

Applicant Information

Organization _____ Contact Person _____
Mailing address _____
City, state zip _____ County _____
Phone _____ Fax _____ Website _____
E-mail address _____

Donation/Sponsorship Information

Mission of organization _____

Program or project title _____ Program date _____

Explain how this request relates to one or more of the three key objectives for charitable donations as described in the guidelines.

What is the projection of the following to benefit from this program or project?

Number of attendees _____ Age group _____ Gender _____

Describe any other related projections _____

Please check one of the following and provide the relevant information.

In-kind donation requested Financial donation requested
 Volunteers, qty. _____ Dollar amount requested \$ _____
 Other, describe _____

Please check any of the following outcomes for Danville Regional that apply.

Media coverage Marketing opportunities Inclusion in promotional material Signage
 Other, describe _____

Please indicate any of the following you need to promote Danville Regional Medical Center accordingly. Please forward a link to website or electronic proof of print material where our logo is used to confirm proper treatment of logo.

Logo, print version Logo, web version Website address Ad

Please provide a list of other donors and indicate whether they are potential or committed. _____

_____ 7/2017 _____

NOTE: Please fill out this form in its entirety. Incomplete applications will be returned without review. Please include with this application: a) documentation of your organization's 501c(3) status; b) a completed LifePoint Supplier Ownership Certificate; and c) copy of your organizations signed W9 application.

Organizations receiving sponsorship or donation must complete and return the Post-event Outcomes Form within 15 days of the program completion date. Failure to do so may impede future sponsorship or donation requests.

Please return your application by mail or e-mail to one of the addresses indicated below:

Mail: Danville Regional Medical Center
Attn: LeAnne Roller
142 South Main Street
Danville, VA 24541

E-mail: jeanne.roller@lpnt.net



Please return this form within 15 days of the program completion date by e-mail or fax. E-mail: leanne.roller@lpnt.net
Fax: 434-799-4587

Recipient Information

Organization _____ Contact Person _____
 Phone _____ Fax _____ Website _____
 E-mail address _____
 Program or project title _____ Program date _____

Program Outcomes

How many people were impacted by or participated in the program or project? _____

Health areas addressed in project (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Access to primary medical care | <input type="checkbox"/> Access to specialty/subspecialty care |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease/stroke |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Teen pregnancy prevention | <input type="checkbox"/> Vision exams (children) |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |
- | | |
|---|---|
| <input type="checkbox"/> Dental care (children) | <input type="checkbox"/> Dental care (adults) |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Infant mortality |
| <input type="checkbox"/> Physical activity/exercise | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Vision exams (adults) | <input type="checkbox"/> Other _____ |

Racial/Ethnic groups served during this project (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Other _____ | | |

Gender of participants impacted by the project: Male Female

Age groups of participants impacted by the project (complete the age range):

- | | |
|--|---|
| <input type="checkbox"/> Prenatal (_____ to _____) | <input type="checkbox"/> Adolescents (_____ to _____) |
| <input type="checkbox"/> Infants (_____ to _____) | <input type="checkbox"/> Adults (_____ to _____) |
| <input type="checkbox"/> Children (_____ to _____) | <input type="checkbox"/> Elderly (_____ to _____) |

The goals of the project/program were met to your satisfaction: Agree Disagree Neutral

If the requested financial donation or sponsorship was not used in its entirety, please explain how the remaining funding will be utilized.

How was Danville Regional recognized as a donor or sponsor? Please attach printed materials or include website links, if applicable.

Please provide any additional information relevant to your organizational outcomes and Danville Regional outcomes.
