



Marshfield Clinic
 HEALTH SYSTEM
 FOUNDATION

Gift-In-Kind Donation Form

PLEASE PRINT

Date: _____

Company or Individual: _____

Contact Person: _____

Street or PO Address: _____

City/State/Zip: _____

Phone: _____ **Email:** _____

Item/Service Donated – Please provide a detailed description of item or services donated. For gift certificates or services, please include an expiration date or other important information.

Event: _____

***Fair Market Value: \$** _____

- Item is attached
- I will pick up the item and deliver to the MCHS Foundation Office
- Item will be mailed/delivered on date _____
- Item needs to be picked up after date _____
- Certificate needs to be made

Additional Comments: _____

Committee Member _____

Marshfield Clinic Contact: _____

As you complete this form, please note that each **donation must have a *FAIR MARKET VALUE assigned**. This dollar figure should reflect the actual cost to attain or the expense of materials to create the particular item. Items may need to be analyzed on an individual basis.

Please return this completed form to:
 Anna Selk – MCHS Foundation – 1R1
 1000 North Oak Ave., Marshfield, WI 54449
 Fax: 715-389-4367 Phone: 715-389-5146
 selk.anna@marshfieldclinic.org

Thank you!

Office Use <input type="checkbox"/> Do not mail <i>BenchMarks</i> <input type="checkbox"/> Anna reviewed
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