

UCLA Health Sciences Development: DONOR-INITIATED FUNDRAISING EVENT APPLICATION

Name of event organizer: _____

Proposed event name: _____

Address: _____ City: _____

State/Zip: _____ Phone: _____ Email: _____

Event description/objective: _____

Proposed location: _____

Proposed event date: _____ Estimated attendance: _____

Event website (if applicable): _____

Ticket price (if applicable): \$ _____ Fair Market Value* of ticket (FMV): \$ _____

**FMV is the value of the goods and services the participant will receive for attending. Even if the event is underwritten, goods and services need to be disclosed.*

Expected charitable proceeds: \$ _____

Area of UCLA Health Sciences to be supported: _____

(department/program/physician)

Will the event proceeds be shared with any other organizations? If so, please list: _____

Is this, or will this be an annual event benefiting UCLA Health Sciences? Yes No

Is there a special reason why you selected UCLA? _____

*For further information or assistance, please contact UCLA Health Sciences Development at
HSDAnnualGiving@support.ucla.edu or (844) 474-4387.*

I have read and understand the *Donor-Initiated Fundraising Event Guidelines* and agree to hold UCLA harmless for any damages, injuries, and liabilities resulting from the event.

AGREED TO AND ACCEPTED BY:

Donor-initiated event name: _____

Signature: _____ Today's date: _____

Print name: _____ Title (if applicable): _____

Please submit the completed and signed form to HSDAnnualGiving@support.ucla.edu.
The Development Office will review the information and get in touch with the Event Organizer to speak about next steps.

