Blank Children's Hospital
UnityPoint Health

Group Project Form

Name of Group:_____

Contact Name:_____

Address:_____

Phone (Day):_____ (Evening):_____

Email:_____

Type of Project/Event:_____

Requested date/time to bring your project:

(A representative from Blank Children's can meet with you, or you can leave your donations at Blank Administration M-F, 8 a.m. to 4:30 p.m. After-hours donations will need to be dropped off at the Main Desk at Iowa Methodist Medical Center.)

First Choice:_____ Second Choice:_____

Donations/Gifts (description):_____

_____

Volunteer Hours:_____

(If you made a donation, thank you for the time you spent planning, purchasing and/or preparing your donation. Please include all this time when you report your volunteer hours.)

Mail to: Blank Children's Hospital
Attn: Community Relations
1200 Pleasant Street
Des Moines, IA 50309

Fax to: 515.241.5127
Attn: Community Relations

FOR OFFICE USE ONLY

Scheduled Date:_____

Scheduled Time:_____

Total # Participants:_____

Total # Hours:_____