CalvertHealth™

In-Kind Contribution Form

Name of Donor Organization or Individual: ____

Address: ____

City: ______________________________ State: ____________ Zip: _______________________

Phone: __________________________ Email: ____

Contact Person (if a business or organization) (*please print*): _______________________________________

Date of contribution: ____

Description of item(s) donated (please include, if possible, detailed description of item and quantity of each donated): ____

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Retail Value, if known: ____

◻ *Please check here is you are a business or organization who seeks to have this contribution of materials replaced by CalvertHealth in the future.*

Please accept our most heart-felt gratitude for your generosity and for choosing to support our local community hospital. Every gift is important, every gift is appreciated and every gift makes a difference.

For questions please contact:
CalvertHealth Foundation, Inc.
410-414-4507
foundation@calverthealthmed.org

CalvertHealth Medical Center, Inc.
Tax ID: 52-0619000