

NON-CASH DONATION FORM

Please complete this form if you plan to donate **ITEMS totaling more than \$250**. Please **CALL AHEAD** at (254) 935-4185 to schedule your donation drop-off.

USE BLACK INK ONLY

Date: _____

Designation (for Foundation use only):

Foundation: BSW Central Texas Foundation
Department: Child Life
Facility: BSW McLane Children's Medical Center

Designation: 62242 (Child Life)
Appeal Code: McLane Children's
Package Code: Children's Hospital

Title: Mr. Mrs. Ms. Miss Dr. Reverend Honorable

Donor Name: _____

Company (if applicable): _____

Company Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Home Work Cell Other

Email: _____

Non-Cash Donation Items:

#	Item Description	Quantity	Estimated Value
1			
2			
3			

Additional fields on reverse side.

Total Estimated Value: \$ _____

Notes: _____

Your contribution to this 501(c)3 organization is tax-deductible to the extent allowable by law.

Donor Signature: _____ Date: _____

To be completed by BSWH

BSW Representative Name: _____

BSW Representative Email or Phone: _____

BSW Foundation Staff Name: _____

BSW Foundation Staff Email or Phone: _____

