BROADLAWNS MEDICAL CENTER FOUNDATION

In-Kind Donation Receipt

Donor Information:

Name of Donor: _____

Contact Person: _____ Title: _____

Address: _____ Phone: _____

City/State/Zip: _____ Email: _____

Donation Information:

Date of the donation: _____

Description of donated item(s):

_____

_____

_____

Purpose of Donation: ☐ **UNRESTRICTED (Area of Greatest Need)**, for the general tax-exempt purposes of Donee, but without other restriction as to use.

☐ **RESTRICTED:** _____.

The donated item(s) are valued by the donor at: $_____*

* Donor acknowledges that donation values can only be recognized for tax reporting purposes, if supported by required documentation. For example, in-kind donations exceeding a certain threshold (e.g., $500.00 or $5,000, depending on donation type) may require value confirmation from an independent qualified third-party appraiser. In such an event, Donor agrees to provide Donee a copy of that qualified appraisal. In the absence of a qualified appraisal, the above value represents Donor's best estimate of the fair market value of the donation at the time it was given. Donor represents that the above donated item(s) will be transferred to Donee on a lien-free basis and shall be the sole property Donee. Donor acknowledges that no gifts or services were received or expected in return for this gift unless otherwise specified below.

Signed: _____ Date: _____

Donor's signature

☐ Please check here if you do not wish to be recognized for your gift by the BMC Foundation within the annual donor report or on the Donor Recognition Board in the Medical Center lobby.

Donee Written Acknowledgement:

Donee (_____) acknowledges the receipt of the above in-kind donation and that Donee has not provided any goods or services to the Donor in return for the above donation unless otherwise stated here: _____.

BROADLAWNS MEDICAL CENTER:

Signed: _____ Date: _____

BMC representative

{Circle one: Senior Executive Service Line Manager Patient Advocate Social Services Foundation Representative}

BROADLAWNS MEDICAL CENTER FOUNDATION:

Signed: _____ Date: _____

BMC Foundation representative

{Circle one: Senior Executive Service Line Manager Foundation Representative}

Please return signed receipt to:

Broadlawns Medical Center Foundation
1801 Hickman Road
Des Moines, IA 50314
(515) 282-2496

Thank you for helping Broadlawns achieve its mission of providing quality healthcare that is coordinated, cost-effective, and accessible to our community.

Permission to use Photography and/or Videography:

I grant permission to Broadlawns Medical Center, including its trustees, officers, employees, agents, and staff, the right to take photographs or video of me and my property in connection with the marketing and public relations materials for Broadlawns Medical Center and/or for Broadlawns Medical Center's benefit. I consent to the taking of photographs, videos, audio recordings, and televised material, and authorize the use of my name in the materials. I authorize Broadlawns Medical Center, its assigns and transferees to copyright, use, and publish the same in print, video, and/or electronically.

I agree that Broadlawns Medical Center may use such photographs or videos of me, with our without my name, and for any lawful purpose, including but not limited to publicity, illustration, advertising, social media, and web content. I understand that I will not be compensated for any usage of any photographs or videos by Broadlawns Medical Center. I also acknowledge that Broadlawns Medical Center, its trustees, officers, employees, agents, and staff are released from any liability in connection with production, publication, and/or use of such materials.

_____
Printed Name

_____
Signature

_____
Address

_____
Date

_____
Signature, parent or guardian (if under age 18)