Dignity Health Foundation®
Inland Empire

IN-KIND GIFT DOCUMENTATION

Date of Gift: _____

Donor Name: _____

Address: _____

_____

City: _____ **State**: _____ **Zip Code**: _____

Telephone: _____

Description of item:

_____

_____

Value of Item for <u>Donor Recognition Purposes Only</u>: $ _____

Method of computing value (please attach copy of one of the following):

- ❑ **Appraisal from Independent Appraiser (required by IRS for gifts valued over $5,000)**
- ❑ **Invoice**
- ❑ **Donor-Written Statement**
- ❑ **Department-Determined Valuation**
- ❑ **Other (please specify)** _____

Hospital to receive item: ❑ Community Hospital of San Bernardino

❑ St. Bernardine Medical Center

_____

Donor Signature **Date**

_____

Vice President for Philanthropy **Date**

(Signatures required before gift is accepted by the Dignity Health Foundation Inland Empire office)