

**Arkansas Children's Hospital
Mock Party/Special Donor Information**

Name of Group _____

Contact Person _____

Address _____

E-mail Address _____

Phone _____ Home _____
_____ Work _____
_____ Cell _____
_____ Message _____

Date of Event _____ Time of Event _____

Place of Event _____

Brief Description of Program/Project:

Will any money be raised for this event? If so, what types of fundraisers will be held?

Will any businesses or organizations be solicited? If so, please list.

Anticipated number of participants for the event

Any additional information:

****Arkansas Children's Hospital is responsible for all media contact.
Any media coverage must be approved by Public Relations prior to the event.****

*ACH Volunteer Services
800 Marshall Street Slot 108
Little Rock, AR 72202*

*(501) 364-1825 Phone
(501) 364-6251 Fax*