Associate Crisis Fund Request

Name: ____

Home Address: ____

Phone: ____________________ E-mail: ___________________________________

Department/Office: _________________________ Director: _________________

Amount of Request: ___________________

Please describe your situation and how you will use the requested funds. (Attached supporting documentation, if applicable)

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I certify that I am employed by Hancock Regional Hospital or Hancock Physician Network. I have read the Associate Crisis Fund eligibility guidelines and I agree that the Foundation has the right to release my name and explanation of my hardship to the LIFT Committee or my Director to obtain assistance with my financial hardship as stated above.

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Signature

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Date