

DUKE HOSPITAL AUXILIARY PROJECT REQUEST FORM

OUR MISSION

Duke Hospital Auxiliary's primary goal is to support hospital programs through financial support with particular emphasis on patient and family needs that raise the level of patient care and comfort.

Date of Request: _____

Division or Department: _____ Department Head: _____

Name & Title of person requesting: _____

Mailing Address For Check: _____ Email Address: _____

Phone Number: _____

Fax Number: _____

PLEASE LIST THE NAME OF ENTITY THE CHECK SHOULD BE MADE TO IF REQUEST IS APPROVED

Do you have a Duke Development contact and if so, please list their name and email?

Beginning **July 1, 2026**, please submit anticipated funding needs for the full fiscal year to support equitable allocation of Auxiliary funds.

Amount of Funds Needed: _____

Item(s) for which funds are requested (please include itemization, prioritization, and cost breakdown):

Explanation of Need: _____

Because we are no longer a part of the Duke University system, we will not be able to transfer money. Therefore, a check will be written. Information will be needed to assist us with this process. Due to the board meeting quarterly, project requests need to be received by July 1, October 1, January 1 and April 1 to be considered at the next meeting.

Return to both: Lucille Dwyer, Projects Chairman lucilledwyer@gmail.com (919)596-6782 and Linda Simpson, President lmskoala43@aol.com (919)493-3797

Any questions may be directed to: Linda Simpson, lmskoala43@aol.com, OR Lucille Dwyer, lucilledwyer@gmail.com. MAILING ADDRESS: P.O. Box 61366, Durham, NC 27715

Date Presented to Board: _____ Date of reply: _____

Status: Approved ☐ Denied ☐ Check one) Reason for Denial (if denied): _____

Please state how our donation will be recognized. Please use our logo and www.dukehospitalauxiliary.org for any recognition.