HEALTHPAC CONTRIBUTIONS – TRANSMITTAL FORM

Please complete and return this form with each set of contribution forms and checks you return. Feel free to copy this form as needed.

HEALTHPAC contributions must be forwarded within five days of receipt to comply with state law. ***A contribution form must be completed in its entirety and accompany each contribution. Please submit contributions on a weekly basis.***

Name of Hospital/Health System: _____

Contact Person: _____

Title: _____

Email Address: _____

Phone Number: _____

Total number of HEALTHPAC checks submitted: _____
(The signature on the check must be that of the contributor.)

Total amount of HEALTHPAC contributions submitted: $_____

Mail to:

Missouri Hospital Association
P.O. Box 60
Jefferson City, MO 65102-0060