MEDICAL COLLEGE *of Georgia* FOUNDATION

Fund Change Request

Date ____________

Fund Representative ____________ Title ____________

Telephone Number ____________ E-mail ____________

Request to Close Fund

Fund Number ____________ Fund Name ____________

Reason:

Request to Change Fund

Fund Number ____________

Current Name

New Name

Current Purpose

New Purpose

Reason:

Department Authorization

President, Dean or Chairman ____________ Date ____________

Print Name ____________

Date Approved by Board: ____________

MCGF Processed By: ____________

Please submit all original documents (this form and supporting documentation) to :
MCG Foundation at 720 St Sebastian Way Suite 150 Augusta, Georgia 30901 (Attn: Accounts Payable)

Please refer to our Fund Maintenance and Administration policy for more details.

01/20