dream catchers

Agreement to Become a Hospice Partner

Name of Hospice (City/State): _____

School Chapter Partner (if known): _____

Official Hospice/Chapter Liaison Name(s):_____

Job Title: _____

Liaison Email Address: _____

Liaison Phone Number: _____

Preferred Contact Method:

☐ Phone (Call) ☐ Phone (Text) ☐ Email ☐ Other (please specify):_____

We understand that signing this agreement makes us an official hospice partner of the **Hospice DreamCatchers Foundation, LLC**, and agree to the terms that this partnership entails. We have reviewed the Policy & Procedure manual and agree to uphold the hospice partner Responsibilities as stated. We agree to put the DreamCatchers logo on our website within a reasonable time of signing this agreement and will mention DreamCatchers services in marketing or other materials as deemed appropriate. We understand that we must work to fulfill our chapter partner's stated number of Dreams per month by regularly ensuring that all hospice staff are aware of the DreamCatchers services offered. We agree to be in continuous communication with our chapter partner's leader & properly inform them if the hospice liaison changes. We understand our responsibilities and purpose as a DreamCatchers hospice partner & intend to create a positive, fruitful partnership with our student chapter.

Signed by:

_____ _____

Name **Title**

_____ _____

Signature **Date**