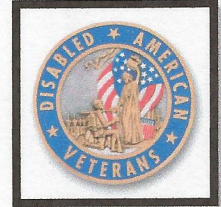




*Disabled American Veterans
Department of Louisiana*



CHAPTER/UNIT FUND RAISER REQUEST

Name of Chapter/Unit _____

1. Description of Fund Raiser _____

2. Beginning Dates of Fund Raiser _____

Ending Dates of Fund Raiser _____

3. Location of Fund Raiser _____

4. Name of Person or Organization Conducting Fund Raiser _____

5. Designate what Funds are to be used for _____

6. Designate when Funds are to be used _____

7. Is Revenue from Fund Raiser expected to exceed \$5,000? (Check one) YES _____ NO _____

Chapter/Unit Adjutant Signature _____ Date _____

Chapter/Unit Commander Signature _____ Date _____

Department Adjutant Signature _____ Date _____

Department Commander Signature _____ Date _____

(IF REQUIRED) DEC APPROVAL _____ YES _____ NO _____ DATE _____