



Photo Release

PHOTOGRAPHER INFORMATION

Name: _____

Phone Number: _____

Email: _____

Address: _____

Call for Submissions:

- Photographs must be taken in Central Illinois.
- Photographs must be owned by the submitter.
- No compensation will be received for having a photograph selected and displayed by HSHS St. John's Hospital.
- St. John's Hospital will print, size and curate the work at its discretion.
- Limit two photographs per person.
- Files must be high-resolution, at least 5 MB.
- Applicants should not watermark or sign entries.
- Files must be hand-submitted by **March 22, 2018 to HSHS Central Illinois marketing department at**
 - **850 E. Madison St., 2nd floor, Springfield, IL 62702**
- Email entries will not be accepted.
- CDs or jump drives will not be returned to owners.
- This photo release must accompany files or they will not be considered.
- Email further questions to **lane.fowler@hshs.org**

ENTRY #1

Filename: _____

Photo Location: _____

ENTRY #2

Filename: _____

Photo Location: _____

For Official Use Only by Hospital Sisters Health System Affiliates

Thank you for submitting your photos for use by the HSHS St. John's Hospital Cancer Center. This form serves to verify that you own the copyright and hereby grant HSHS St. John's Hospital permission to use your photos in a way but not limited to as followed: printing the photos, displaying them on the walls of HSHS St. John's Cancer Center, posting the photos on any of the Hospital Sisters Health System (HSHS) affiliated social media account pages and websites.

By signing below, you certify that you hereby grant HSHS St. John's Hospital permission to use, print, display and distribute your photos on a royalty-free basis.

I, _____ am the owner of and hold the copyright on these photos and understand and agree to the terms of this form.

Signature _____ Date _____