SPONSORSHIP AGREEMENT FORM

THE DERBY RUN FOR COMMUNITY HOSPICE & PALLIATIVE CARE

Sponsor Name: _____

Please print exactly as you wish name to be listed in promotional materials

Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Number: _____ Email: _____

I would like to be included as a _____ Sponsor.

❑ I would like to pledge $_____. Please bill me (Payment due by April 27, 2018)

❑ Enclosed is my check for $_____.

❑ Unable to attend please accept our contribution for $_____.

❑ Please charge my Visa/MasterCard/Discover/American Express $_____.

Name as it appears on card _____

Card #_____

Exp. Date _____

Billing address, if different than above: _____

*Make secure payments online: DerbyRun.CommunityHospice.com

_____ _____

Signature Date

Please keep a copy and return this form to:
Community Hospice & Palliative Care Foundation, Attn: Donna Morrow, 4266 Sunbeam Road, Jacksonville, FL 32257, Fax: 904.886.3885

Contact: Donna Morrow, 904.407.6136, dmorrow@communityhospice.com