Sponsorship Pledge Form

Please complete ALL appropriate sections of this application and return on or before January 16, 2017.

	Compar Organiz	-				
	Organiz		(Exactly as it is to be printed in all acknowledgments)			
	Contact	Name:				
	Contact	Title:				
Address: City/State/Z		:				
		te/Zip:				
	Phone/	-ax:				
	E-mail A	ddress:				
	Website	::				
		orship Packages				
Please select your level of sponsorship:						
		Platinum Level		\$25,000		
		Gold Level		\$15,000		
		Silver Level		\$7,500		
		Bronze Level		\$5,000		
	Exhibit	Exhibitor				
		Corporate rate		\$1,500		
		Community-based nonprof	it rate	\$1,000		
	Subtota	l Premium Sponsorship:	\$			
	Subtotal À la Carte:		\$			
	TOTAL AMOUNT:		\$			

Payment Informatio	n:	
Check Enclosed	d Credit Card	☐ Send Invoice (paid in full by January 16, 2017)
(Checks should be	made payable to: Cor	mmunities Joined in Action)
Please complete t	his sponsor pledge fo	rm and forward with payment to:
	ace, 8 th Floor	t the Georgia Health Policy Center
Credit Card Information	on:	
Amount to be charged	:\$	
First Name:		Last Name:
Credit Card Details (Ch	eck one) Master Card	☐ American Express ☐ Discover.
Credit Card Number:		
Expiration Date:		CSC:
		Card Security Code: For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.
Billing Address:		
City/State/Zip:		
Authorized Signature		Date

Questions: Contact Stephanie Ondrias at sondrias@texashealthinstitute.org or (512)279-3920.

CJA Tax ID #: 52-2305386