Augusta Health Foundation

Corporate Partner Statement of Gift Intent

ORGANIZATION NAME: _____
(For recognition purposes, please indicate exactly how your company name should appear)

CONTACT NAME: _____

TITLE: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE: (OFFICE) _____ (CELL) _____

EMAIL: _____

Please indicate your Corporate Sponsorship commitment level: (may be paid over 4 years)

☐ Philanthropic Leaders	$1,000,000+	☐ Champions	$50,000+
☐ 1994 Visionaries	$ 500,000+	☐ Advocates	$ 25,000+
☐ Partners	$ 100,000+	☐ Sustainers	$ 10,000+

Please select the frequency of your sponsorship gifts: ☐ Lump sum ☐ Annually

Please choose your sponsorship payment method:

☐ Check — Make checks payable to Augusta Health Foundation and mail to the address below. You will receive reminder statements based on the payment frequency you select.

☐ ACH — Email ahfoundation@augustahealth.com for account details.

Please email your logo in EPS and JPG format to: ahfoundation@augustahealth.com

Thank you for your partnership and support!

Augusta Health Foundation
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540-332-5174 | ahfoundation@augustahealth.com
www.augustahealth.com/foundation