

Samaritan Club

I accept this invitation to annually participate in the Samaritan Club designation offered by Commonwealth Health Foundation. I hereby signify my intention to contribute as follows:

\$ _____ Gold (\$500+ annual)

\$ _____ Silver (\$250 - \$499 annual)

\$ _____ Bronze (\$100 - \$249 annual)

Payment of \$ _____ is enclosed.

Signature of Donor

Date

Recognition Name: _____

(Please print your name as you want it to appear in donor listings)

Please recognize my/our gift as Anonymous.

Mailing Address: _____

Home Phone: _____ Business Phone: _____

E-mail address: _____

Please make your check payable to Commonwealth Health Foundation and return with the completed form to

Commonwealth Health Foundation

800 Park Street

P.O. Box 1868

Bowling Green, KY 42102-1868