

# Day of Hope

Sponsorship Form  
2019

**Yes, I want to support local cancer patients!**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Company (if applicable): \_\_\_\_\_

Name as you would like it to appear on sponsorship materials: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

[supportmarianmedical.org](http://supportmarianmedical.org)

## LEVELS

- Inspire Sponsorship . . . . . \$20,000
- Hope Sponsorship . . . . . \$10,000
- Dignity Sponsorship . . . . . \$5,000
- Justice Sponsorship . . . . . \$2,500
- Excellence Sponsorship . . . . . \$1,500

Deadline to reserve space is **February 1**.

Please submit logo by **February 1**.

Please submit all logos in PDF or TIFF format with no crop marks as full-color CMYK documents.

For questions, call 805.739.3595 or e-mail [Shelby.McLean@dignityhealth.org](mailto:Shelby.McLean@dignityhealth.org).

## PAYMENT

Total: \$ \_\_\_\_\_

Enclosed check made payable to Marian Foundation

Card Type:  Visa  Mastercard

Card No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on the Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

No, I will not be a sponsor for the 2019 Day of Hope; however, I would like to make a donation.

