

YES, I _____ would like to invest in MCHC's commitment to,
please print your name "Health Care for a Stronger Community".

1. Tell us about your Pledge.

I would like to make a **Pledge Commitment** in the amount of:

\$1,000 \$500 \$25 \$100 Other \$ _____

The amount indicated above will be evenly split over the number of years you indicate below.

Paid over a period of: 1 year 2 years 3 years

2. Pledge Terms

Please invoice me as indicated below. *(Include the date you would like us to send your first invoice.)*

Quarterly Semi-annually Annually

Date you would like to receive your first invoice. _____ _____ _____
Date *Date* *Date*

3. Tell us if you have a preference for where you would like your gift directed?

Please direct my contribution to: (select all that apply and indicate the amount)

- | | |
|--|--|
| <input type="checkbox"/> Unrestricted/General Operating (\$ _____) | <input type="checkbox"/> New Building Fund (\$ _____) |
| <input type="checkbox"/> Direct Service Program (\$ _____)
Including adult and pediatric primary care and prenatal care to the uninsured underinsured | <input type="checkbox"/> Support Services (\$ _____)
Including; counseling, nutrition services, patient education, language interpretation, and prescription assistance |

This contribution is in memory of: _____

Please send acknowledgement of this gift to: _____

Address: _____ City _____ State _____ Zip _____

4. We will contact you to verify your preferences indicated on this form.

Your name: _____ Your phone number: _____

I understand that I am committing to contribute \$ _____ over a period of _____ year(s) whereby I will be invoiced for a total of _____ (number of) installments.

Donor's Signature

Date