McLeod Health Foundation

The Circle of Excellence Commitment Form

❑ **Yes, I/we want to become a member of *The Circle of Excellence* and pledge to contribute $500 or more.**

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Mr. & Mrs. ❑ Rev. ❑ Other_____

Name(s) _____ Date(s) of birth _____
If joining as a couple, please include birth dates for both individuals and note first name with each date.

Address _____
City/State/Zip _____
Phone (H) _____ (W) _____ Cell _____
Email_____
Signature(s)_____Date _____

PLEDGE:
Please bill me: ❑ Monthly ($42) ❑ Quarterly ($125) ❑ Annually ($500) ❑ Other _____

Please consider making a recurring gift–an easy, flexible, green way to make a difference! If you commit to a recurring gift, we will continue to charge your card or bill you on the timetable you've indicated.

❑ Yes, I'd like to make my gift recurring. ❑ No, my gift/pledge commitment is for one year.

CONTRIBUTION:
Enclosed is my/our contribution of: $ _____

Paid by: ❑ Cash ❑ Check ❑ Visa ❑ MasterCard ❑ Discover ❑ AMEX ❑ Bank Draft

Card# _____Exp. Date (MM/YY) _____ 3 digit code:_____

Name on card _____Signature_____

RECOGNITION
For recognition purposes, how would you like your name to appear? _____

This gift is: ❑ in memory of: ❑ in honor of
Send acknowledgement to: _____
Address: _____City/State/Zip _____

❑ This is an anonymous gift.
❑ My company will match this contribution.

Return Completed form to Elizabeth Jones at McLeod Health Foundation.
Elizabeth.jones@mcleodhealth.org | 843-777-2694

-or- mail to McLeod Health Foundation, 800 East Cheves St., Suite 150 Florence, SC 29506 |