UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

PARTNER **AGREEMENT**

(PLEASE PRINT)

COMPANY/INDIVIDUAL NAME (AS IT SHOULD APPEAR FOR FOUNDATION RECOGNITION PURPOSES)

CONTACT NAME (TITLE/SUFFIX: I.E., MR. MS. MRS./PH.D. M.D.) TITLE

BUSINESS NAME (IF DIFFERENT THAN ABOVE)

BUSINESS ADDRESS

CITY STATE ZIP

CELL OTHER PHONE FAX

E-MAIL

Total Gift Amount: $ _____

(PLEASE DETAIL YOUR SUPPORT ON REVERSE)

O I would like to discuss a multiple-year pledge of support.

PAYMENT OPTIONS

O Visa O Mastercard O American Express O Discover

O Amount Included O Invoice Requested O I would like to discuss payment options

NAME (AS IT APPEARS ON CARD)

CARD NUMBER EXP. DATE

ADDRESS

CITY STATE ZIP

DAY PHONE SIGNATURE

Please complete reverse side and return to us.

UNIVERSITY OF MICHIGAN HEALTH
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SUPPORT **DETAIL**

Thank you for your generous support. We look forward to working with you to maximize the impact and benefits of your gift. Should you need anything, please call us at 517-364-3620.

Total Gift Amount: $ _____

(YOUR CONTRIBUTION IS TAX-DEDUCTABLE TO THE EXTENT OF THE LAW)

Authorized Signature: _____Date _____

Please detail how your support should be allocated, using the example below as a guide.

Hospital/Event Ex. Vision & Victories	**Amount** Ex. $10,000	**Preferred Opportunity** Ex. Titanium Sponsor

We will work with you on an alternative if your preferred gift opportunity is no longer available. If your sponsorship includes a logo, please send a high resolution logo to **RegionalNetworkEvents@umich.edu.**

Please complete and return to us:
U-M Health Regional Network Development
1322 E. Michigan Ave., Suite 204, Lansing, MI 48912
RegionalNetworkEvents@umich.edu

_____ _____
Received by Date