Pledge To

____

For Project/Program

____

Please accept this pledge of $________________to be paid over

- ☐ one year
- ☐ two years
- ☐ three years
- ☐ four years
- ☐ five years starting ________________ , _______________.

Month Year

Payments will be made:

- ☐ Annually
- ☐ Semi-annually
- ☐ Quarterly
- ☐ Other_____________________________

Donor Name(s)____

(Please print as you would like to be listed for Donor Wall and/or publications)

Address ____Phone______________________

City_________________________________State_____Zip _________________________

Email address____

Contact name if donor is Business or Organization____________________Phone___________

Signature____Date____________

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greaterregional.org/healthcare-foundation
Phone 641-782-3503