

# PHYSICIAN AND PROVIDER CAMPAIGN



 **CHESAPEAKE REGIONAL  
HEALTH FOUNDATION**

Your commitment to the well-being of our community resonates deeply, and we are immensely grateful for your partnership in our mission. In the face of the rapidly evolving healthcare landscape, your donation enables us to embrace new technologies and interventions that revolutionize the way we deliver healthcare.

## Gifts of all sizes are greatly appreciated!

### MEMBER - \$600

- Name on website and annual report
- Recognition on donor walls
- Special edition CRH t-shirt size: \_\_\_\_\_
- One Bra-ha-ha® 5K Race entry

### PARTNER - \$1,200

- Name on website and annual report
- Recognition on donor walls
- Special edition CRH t-shirt size: \_\_\_\_\_
- CRH hooded sweatshirt size: \_\_\_\_\_
- One Bra-ha-ha® 5K Race entry

### JENNINGS CIRCLE - \$2,600

- Name on website and annual report
- Invitation to Donor Reception
- Recognition on donor walls
- Special edition CRH t-shirt size: \_\_\_\_\_
- CRH hooded sweatshirt size: \_\_\_\_\_
- CRH Signature Gifts
- Invitation to VIP Donor Reception
- Two Bra-ha-ha Award Show & Auction tickets
- Two Bra-ha-ha 5K race entries
- Two CRH Gala tickets

### BUCKLEY SOCIETY - \$5,000+

- Name on website and annual report
- Invitation to Donor Reception
- Recognition on donor walls
- Special edition CRH t-shirt size: \_\_\_\_\_
- CRH hooded sweatshirt size: \_\_\_\_\_
- CRH Signature Gifts
- Special opportunities
- Invitation to VIP Donor Reception
- Four Bra-ha-ha Award Show & Auction tickets
- Four Bra-ha-ha 5K race entries
- Four CRH Gala tickets
- Recognition as Foundation Society Member

### Donation Options:

- ☐ Donation Amount: \_\_\_\_\_ (check enclosed, credit card, cash)
- ☐ PAL donation (for CRH and CRMG employees) # of hours: \_\_\_\_\_  
(if dollar amount is selected, payroll will figure number of hours)
- ☐ CRH payroll deduction (please note total amount given below and it will be divided evenly among 26 pay periods)
- ☐ Automatic monthly credit card donations (spread your gift across 12 easy payments)

Name: \_\_\_\_\_ Office Name/Department: \_\_\_\_\_

Address (City, State, Zip Code): \_\_\_\_\_

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

Total Gift Amount: \$ \_\_\_\_\_ ☐ Check Enclosed ☐ Payroll Deduction ☐ Monthly Payment ☐ Credit Card

Credit Card Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Name on Card: \_\_\_\_\_

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

Signature: \_\_\_\_\_



*Scan to Donate!*

Return form to: **Chesapeake Regional Health Foundation**  
**736 Battlefield Blvd., North, Chesapeake, VA 23320**  
**Foundation@ChesapeakeRegional.com | 757-312-6314**

**Office Use Only**

Fulfilled: \_\_\_\_\_ Data Entry: \_\_\_\_\_