Collie Health Foundation Membership Form

PLEASE INDICATE: New Member _____ Renewed Membership _____

Please check level of membership desired:

_____Individual Membership $25
_____Family Membership $40
_____Sustaining Membership $100
_____Patron $500
_____Benefactor $1,000

I'm interested in volunteering:

_____ Fundraising _____ Sunnybank
_____ Auctions _____Promotions
_____Website _____Education/Grant/Studies
_____Other:_____

(Dues are for a fiscal year from January 1 to December 31 (or from join date to December 31)

Join online at www.colliehealth.org/membership/ or if you prefer to mail a check you can send a check in U.S. funds payable to Collie Health Foundation to: **Johanna Lance, 1631 Holmden Ave. Cleveland, Ohio 44109**

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Email: _____Phone: _____

_____Please check if this is a new address
_____ I have included CHF in my will
_____Please send me information about including CHF in my will.

Do you or your spouse work for a matching gift company? Some companies will match gifs of employees and/or retirees. Please contact your personnel office for details and a matching gift form.

Company Name:_____
Form Enclosed: _____Yes _____ No

ADDITIONAL CONTRIBUTION: _____In Memory _____ In Honor _____ In Celebration

_____

_____

Contributions are tax deductible in accordance with IRS regulations.

Collie Health Foundation, Inc. is a 501(c)(3) non-profit organization. Federal Tax ID #13-3376254