



JUNE 8, 2019

2019 SPONSORSHIP COMMITMENT FORM

Please complete and sign this form to confirm your sponsorship commitment by **May 1, 2019** and send it to:

Medical Teams International
Attn: Field of Dreams
9680 153rd Ave NE
Redmond, WA 98052
events@medicalteams.org

Sponsor Name _____

(Please write name as you would like it to appear in the auction catalog; check here if you would like to remain anonymous)

Address _____

City _____ **State** _____ **Zip** _____

Contact Name _____

Phone _____ **Email** _____

Signature _____ **Date** _____

Yes, I/we will support Medical Teams International's *Field of Dreams Dinner & Auction* by sponsoring the event as a:

- | | | | |
|--|-----------------------------|--|---------------------------|
| <input type="checkbox"/> \$35,000 | Champion Sponsor | <input type="checkbox"/> \$10,000 | Grand Slam Sponsor |
| <input type="checkbox"/> \$25,000 | World Series Sponsor | <input type="checkbox"/> \$5,000 | Home Run Sponsor |
| <input type="checkbox"/> \$15,000 | MVP Sponsor | | |

Yes, I/we want to support Medical Teams International and in place of a sponsorship, I/we prefer to make a contribution of \$_____.

Yes, I/we would like to additionally sponsor Medical Teams International's *Healthy Women, Healthy World Luncheon* in October 2019 at the following level:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> \$10,000 Compassion | <input type="checkbox"/> \$5,000 Hope | <input type="checkbox"/> \$2,500 Wellness |
|--|---------------------------------------|---|

If you choose to combine your sponsorship with our Healthy Women, Healthy World luncheon in October 2019 at the \$10,000 or \$5,000 levels, we will increase your Field of Dreams recognition benefits by the corresponding amount.

Payment Options:

- Please invoice me for sponsorship fees.
- Enclosed is a check for \$_____. Please make checks payable to Medical Teams International.
- Please charge my Visa MasterCard American Express Discover card for \$_____.

Credit Card Number: _____ Expiration: _____

Name of Cardholder: _____ Signature: _____

If paying by card, please ensure that your billing address is included in the fields at the top of the page.

Internal Use Only

CRM ID: _____ Project: _____ Proposal: _____

Medical Teams International Federal Tax ID #93-0878944

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