24th Annual

MERCY MEDICAL Charity Golf Tournament

Our community has never needed you more.

Thursday, Sept. 23, 2010 • Rock Creek Golf Club • Fairhope
SPONSORSHIP & DONATION PLEDGE FORM

Yes, I want to support Mercy Medical's Patient Charity Care programs via the 24th Annual Mercy Medical Charity Golf Tournament. ***I understand my pledge is payable in full on or before August 30, 2010.***

__ **PRESENTING SPONSOR ~ $10,000** – Four players - See sponsorship levels for details.

__ **PLATINUM SPONSOR ~ $3,500** – Four players - See sponsorship levels for details.

__ **GOLD SPONSOR ~ $1,000** – Includes sign at tee box, selected publicity, and two players.

__ **SILVER SPONSOR ~ $500** – Includes selected publicity and one player.

__ **ADDITIONAL PLAYERS ~ #_____** player(s) at **$175*** each **AMOUNT $ _____**

*** Player fee includes lunch, practice range balls, greens fee, cart fee, beverages on the course, post-tournament refreshments, great prizes, *PLUS* two mulligans, and the opportunity for each team to select a hole (# 5 excluded) on which they will have the added benefit of hitting from ladies' tee.**

__ **DONATION ~** I will not be able to participate as a sponsor, but would like to make a donation.

DONATION AMOUNT $ _____

TOTAL PLEDGE AMOUNT $ _____

__ I would like to donate an item (gift certificate/door prize/etc.) to help Mercy's tournament. Please contact me for details and to make arrangements for securing the item.

PLEASE PRINT LEGIBLY

Sponsor name: *(as it will be listed in publicity)* _____

Mailing Address**:** _____

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

Contact Person: _____ Phone: _____

FAX: _____ Email: _____

TEE TIME: OUR PLAYER(S) WILL PLAY: *(please check one)* **____ A.M. Shotgun (7:30 A.M.) OR**

____ P.M. Shotgun (1 P.M.) OR ____ NO PLAYERS

_____ _____ _____

Signature *Please print name and title* *Date*

PAYMENT METHOD: (**Payments due by August 30, 2010)**

__ Check enclosed: Make payable to Mercy Medical, Attn: Development, P.O. Box 1090, Daphne, AL 36526

__ Check to follow. __ Please send an invoice.

__ Please charge my credit or debit card ___ Visa ___ MasterCard ___ Discover Card

Card number: _____ _____ _____ _____ Expiration date: _____/_____

Cardholder's name: _____ Signature Panel Code _____

(LAST 3 DIGITS ON BACK OF CARD)

Cardholder's address: _____ City _____ St _____ Zip _____

Please complete and fax your pledge form to the Development Office at FAX # 251.621.4324 or email it to development@mercymedical.com. We will contact you to discuss your players and confirm other details of your participation. Questions? Please call 251.621.4884. Thank you for your support of Mercy Medical!

Mercy Medical is a non-profit 501(c)3 organization. Federal tax ID #63-6002215. Please write to us at P.O. Box 1090, Daphne, AL 36526 if you wish to have your name removed from the list to receive fundraising requests supporting Mercy Medical in the future.