

PRESENTED BY DALE BROWN

Sponsorship Levels

Slam Dunk

\$10,000 – Presenting Sponsor

- ① Sit at table with Coach Brown
- ① 2 tables (18 tickets)
- ① Your logo/name on invitations (*if secured before printing*)
- ① Recognition as presenting “Slam Dunk” sponsor in all pre- and post-event publicity & printed materials including event program and Voice of Mercy
- ① PSA recognition pre-event
- ① Website intro with link to your site
- ① Acknowledgment throughout the event as “Slam Dunk” sponsor
- ① May set up booth at event
- ① Your logo or name on event T-shirt

Nothin’ But Net

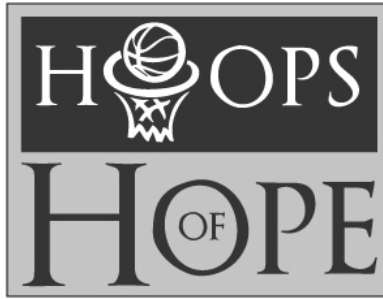
\$5,000

- ① 1 table – 1st row (10 tickets)
- ① Your logo/name on invitations (*if secured before printing*)
- ① Recognition as a “Nothin’ But Net” sponsor in all pre- and post-event publicity & printed materials including event program & Voice of Mercy
- ① Website intro with link to your site
- ① Acknowledgment throughout the event as “Nothin’ But Net” sponsor

Free Throw

\$2,000

- ① 1 table - 2nd row (10 tickets)
- ① Recognition as a “Free Throw” sponsor in all pre- and post-event publicity & printed materials including event program & Voice of Mercy
- ① Acknowledgment throughout the event as “Free Throw” sponsor



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SPONSORSHIP PLEDGE FORM

Yes, I want to support Mercy Medical's **Hoops of Hope!** I understand my pledge is payable in full on or before February 19, 2010.

SLAM DUNK PRESENTING SPONSOR ~ \$10,000

NOTHIN' BUT NET SPONSOR ~ \$5,000

FREE THROW SPONSOR ~ \$2,000

ADDITIONAL TICKETS ~ # _____ ticket(s) at \$35 each or \$50 a couple **AMOUNT \$ _____**

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

DONATION AMOUNT \$ _____

TOTAL PLEDGE AMOUNT \$ _____

PLEASE PRINT LEGIBLY

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

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone: _____

FAX: _____ Email: _____

PAYMENT METHOD: (Payments due by February 19, 2010)

Check enclosed: Make payable to:

Mercy Medical, Attn: Development Office, 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 _____

Signature

Please print name and title

Date

**Please complete and fax your pledge form to the Development Office, fax # 251.621.4324
or mail to Mercy Medical, Development Office, P.O. Box 1090, Daphne, AL 36526**

Mercy Medical is a non-profit 501(c)(3) organization, federal tax identification # 63-6002215.