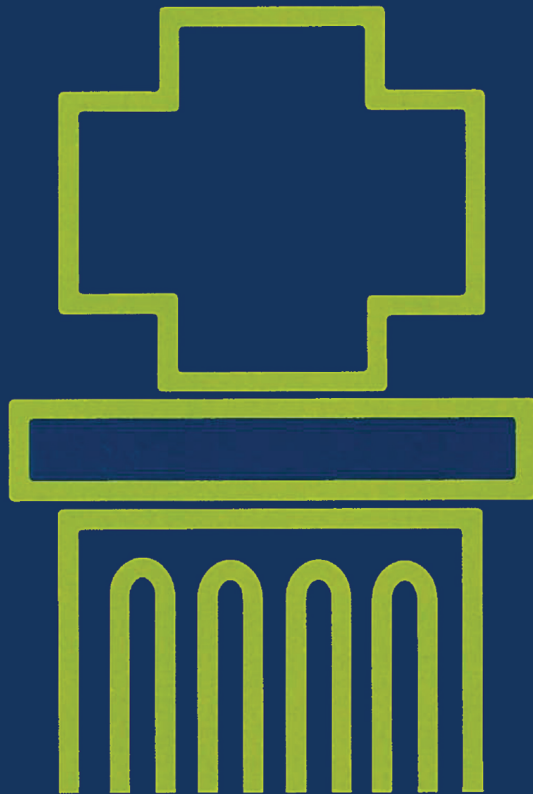


One Vision.
One Institute.
One Community.
One Business Partner.



Hamilton Business Alliance Corporate Gift Pledge Card

I accept your invitation to become a Hamilton Business Alliance member of the Whitfield Healthcare Foundation.

Business Name _____

Representative's Name _____

Title _____

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Mailing Address _____

City _____

State _____

Zip _____

Business Phone _____

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Our company pledges \$_____ over a five year period to support and advance the quality of health services provided by Hamilton Health Care System.

Check for \$_____ enclosed.

Please send a reminder of payment Annually Semi-Annually

The first payment of \$_____ will be made in _____
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Charge \$_____ to : Visa MC Disc AMEX

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