2017 SPONSORSHIP FORM

CHIIP HEALTH FAIR & EXPO

LIFT HEALTH

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____ Cell: _____

Organization: _____ Position: _____

PLEASE SELECT SPONSORSHIP:

- ☐ Title Sponsor $5,000
- ☐ Health/Wellness Sponsor $3,000
- ☐ Diet/Nutrition Sponsor $2,000
- ☐ Community Companion Sponsor $1,000
- ☐ Fitness & Training/Athletics Sponsor $1,000

IVDIVIDUAL CHIIP HEALTH FAIR TABLE/BOOTH:

- ☐ Corporate $300
- ☐ Community Business/Org. $150
- ☐ Not-For-Profit $20
- ☐ Other:

GIFT/PLEDGE INFORMATION:

My payment included with this form is: $ _____

- ☐ Check Enclosed: (Make Payable To: LIFT Health Org. Inc. P.O. Box 173056 Tampa FL. 33672
- ☐ Online Payment: (www.lifthealth/donate)
- ☐ PayPal/Square: (info@lifthhealth.org)