**Sponsorship Opportunities**

Campaign Kickoff Event

Thursday May 16, 2024, Baker Lofts Event Center

*Donate Your Time, Talent, and Support!*

□ **Presenting Sponsor: $3,000 or greater**

* Exclusivity as lead sponsor of Donate a Smile: 2024 Campaign Kick-Off Dinner
* Logo recognition on invitation (if secured before April 16)
* Logo recognition on event program (if secured before May 10)
* Logo recognition on campaign materials, recognition in e-Newsletter, HFHC website, and social media
* Speaking opportunity to address the audience at event (on stage opportunity to share with guests
* Reserved seating for up to 16 guests

□ **Event Sponsor: $2,000 or greater**

* Logo recognition on invitation (if secured before April 16)
* Logo recognition on event program (if secured before May 10)
* Logo recognition on campaign materials, recognition in e-Newsletter, HFHC website, and social media
* Reserved seating for up to 8 guests

□ **Campaign Sponsor: $1,000 or greater**

* Logo recognition on event program (if secured before May 10)
* Logo recognition on campaign materials, recognition in e-Newsletter, HFHC website, and social media
* Reserved seating for up to 8 guests

□ **Table Sponsor: $500 or greater**

* Name listing on event program (if secured before May 10)
* Name listing on campaign materials, recognition in e-Newsletter, HFHC website, and social media
* Reserved seating for up to 8 guests

□ **Donor:**

* Support the campaign in the following amount: $

□ **Event Guest:**

* Attend the event to learn more about HFHC and how you can help

For more information visit us online at: hfhclinic.org/donate-a-smile-campaign

**Contact Information:**

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Name:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I/We agree to provide my name as a campaign sponsor, logo use if applicable □ I/We prefer to remain anonymous

**Payment Information:**

Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Method: □ Please Send Invoice □ Check Enclosed □ Credit Card

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_ Security Code:

Signature:  Date:

Please send form and payment to:

Holland Free Health Clinic, 99 W. 26th Street, Holland, Michigan 49423