
COLORADO HEALTH NETWORK INC.

Campaign Pledge Form

I (we), _____, notify Colorado Health Network of my (our) pledge of _____.
_____ The payment terms and usage of the funds are outlined below.

Donor Information (please print or type)

Name (for formal acknowledgment): _____

Address (preferred): _____

City, State, Zip Code: _____

Telephone (preferred): _____ E-Mail Address: _____

Gifts to annual operations as well as capital will be recognized as campaign contributions. Please indicate where your funds should be directed:

- Unrestricted**, please use the gift for area of greatest capital need
- Mind & Body** (behavioral, dental/medical) **Services and Shelter** (financial & housing resources)
- Cupboard & Community** (food bank & other drop in services)

Payment will be made according to following schedule:

Year of Payment	Amount:
20__	_____
20__	_____
20__	_____
20__	_____
20__	_____

I (we) would like to make payments: annually quarterly monthly Beginning _____

If gift is to be matched, include information below:

Recognition Information

Donors will be recognized in campaign materials unless anonymity is requested.

Please use the following name(s) in all acknowledgements: _____

- I (we) wish to remain anonymous Please contact me to discuss naming opportunities

Contact: Richard Blair | Chief Development Officer | 303-962-5316
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Return form via mail or email | richard.blair@coloradohealthnetwork.org

