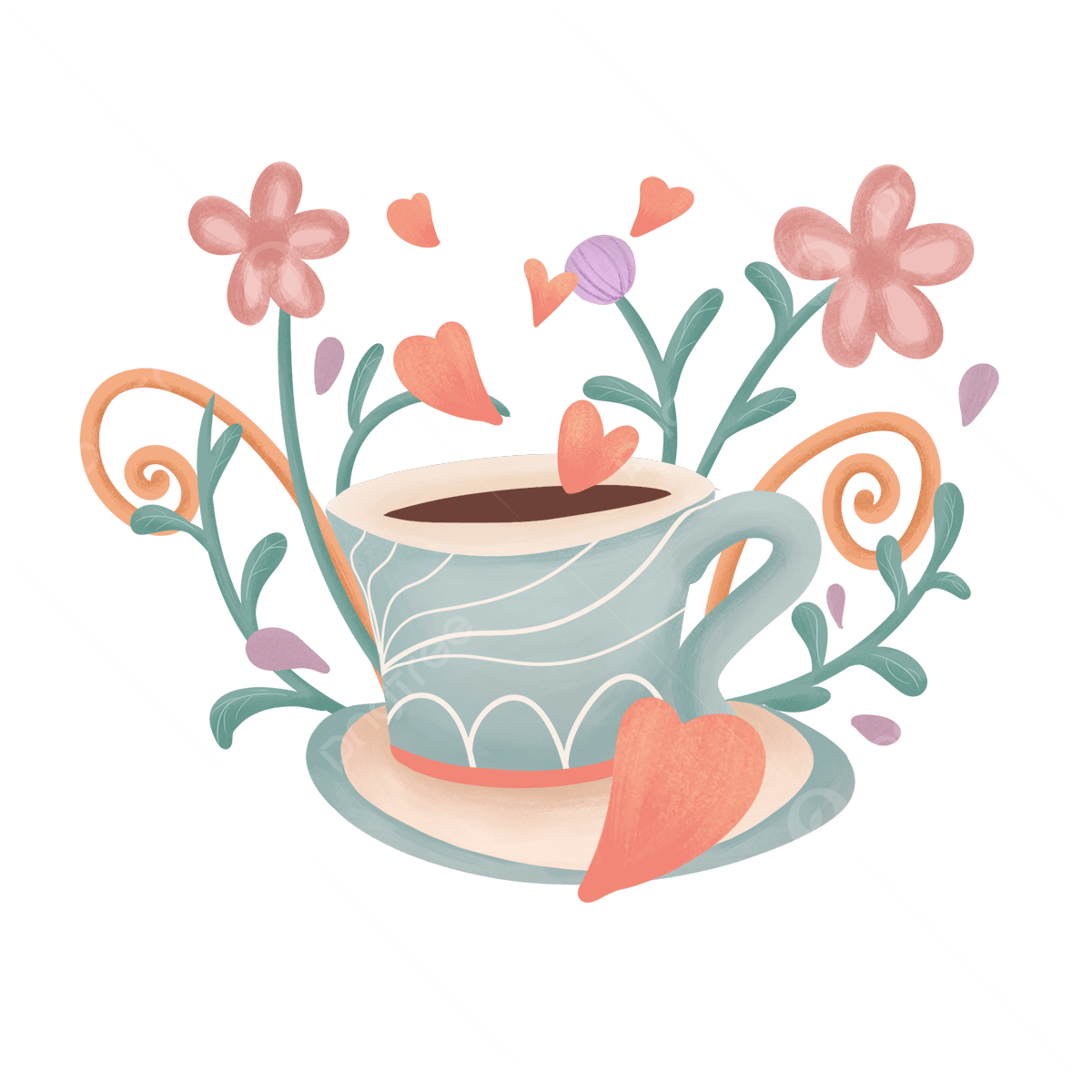
St. Martin’s Healthcare’s

17th Annual Circle of Friends Tea

**“Hope Grows”**

Partnership Form



**Kindly reply by January 30th**

**New Status Level!**

**St. Martin’s Healthcare, Inc.**

**1359 South Randolph Street; Garrett, IN 46738 (260) 357-0077**

**Thank you for your gracious support of St. Martin’s Healthcare, Inc.**

**V Kindly reply by February, 13th!**

**Petit Four Partner $1,000**

**Includes 4 tickets,**

Recognition in the media and on printed event materials designating your level of support.

**Queen Special $5,000**

**Includes 16 tickets with priority seating**, recognition on quarter one & two SMHC magnets, A Special Gift – one for each of your guests, Table Signage at the event with your logo, Recognition in all **pre-event** publicity, on the printed event materials designating your level of support

**High Tea Partner $2,500**

**Includes 8 tickets with priority seating**, A Special Gift – one for each of your guests, Table Signage at the event with your logo, Recognition in all **pre-event** publicity, on the printed event materials designating your level of support

**Cup of Tea Partner $500**

**Includes 2 tickets**, Recognition in the media & on printed event materials designating your support level

**Teaspoon Partner $250**

Recognition in our Tea Program, Recognition in the media and on printed event materials designating your level of support

**Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(How you would like to be listed)**

**Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **My check is enclosed**
* **To make a secure payment by credit card, visit: *www.smhcin.org/circleoffriendstea***
* **Please send me an invoice**
* **I am unable to be a sponsor, but would like to make a donation $\_\_\_\_\_\_\_\_\_\_\_\_\_**

***YES, I would like to Partner with St. Martin’s Healthcare at the level indicated below***