



Please complete the following form for our records:

Name: _____

Occupation/Title: _____

Home Street Address: _____

Home City, State, Zip: _____

Name of Employer: _____

Address of Employer: _____

Employer City, State, Zip: _____

Email Address: _____

Attached is my contribution in the amount of:

___ \$750 Bronze Club

___ \$1,000 Silver Club

___ \$1,500 Gold Club

___ \$5,000 Platinum Club

___ Other \$ _____

Please make checks payable to PHA PAC and send to 5900 South Western Avenue, Suite 102, Sioux Falls, SD 57108

Credit Cards: Visa or MasterCard only.

Visa MC

Credit Card #: _____ Expiration Date: _____

Cardholders Name: _____ Cardholders Signature: _____

*Anonymous contributions are prohibited. However, if you do not want your name to be published in recognition materials, please check this box. _____

FOR MORE INFORMATION OR TO MAKE A DONATION VIA TELEPHONE CONTACT:

PHA at (605) 275-5349 or Fax (605) 731-2575

info@physicianhospitals.org

www.physicianhospitals.org

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