

# Derby Nite Ball

## Sponsorship Form

Company \_\_\_\_\_

Contact Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

### Sponsorship Level

____ \$2,500 Triple Crown Sponsor	____ \$1,500 Daily Double Sponsor
____ \$1,000 Belmont Sponsor	____ \$1,000 Perfecta Sponsor
____ \$1,000 Finish Line Sponsor	____ \$ 750 Clubhouse Turn Saloon
____ \$ 750 Dessert Sponsor	____ \$ 750 Centerpiece Sponsor
____ \$ 750 Hors d' oeuvres Sponsor	____ \$ 500 Middle Distance Sponsor
____ \$ 600 Clubhouse Sponsor	____ \$ 200 Jockey Club Sponsor
____ \$ 300 VIP Sponsor Couple	____ \$ 20 Name Your Own Horse

### Tickets

\_\_\_\_ \$100 Couples \_\_\_\_ \$50 Individuals

How you want your name to appear in print recognition:

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### Please fax or mail to:

Clinton Memorial Hospital Foundation  
P.O. Box 260, St. Johns, MI 48879

Phone: 989.227.3396 or 227.3333  
Fax: 989.227.3347  
Email: CMHFoundation@sparrow.org

INsert

**Please make check payable to CMH Foundation**