

Donor Commitment Form



Name: _____

Please print name exactly as you would like it to appear in recognition

Contact: _____

Title: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Donor Opportunities *(Contributions are unrestricted unless otherwise specified by donor)*

<input type="checkbox"/>	Mental Health Champion \$50,000	<input type="checkbox"/>	Ray of Hope \$25,000	<input type="checkbox"/>	Community of Courage \$15,000	<input type="checkbox"/>	Post Traumatic Growth \$10,000	<input type="checkbox"/>	Helping Hands \$5,000
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Payment Options

Check

Credit Card Visa MasterCard AMEX

Name on Credit Card:

Credit Card Number:

CVV Code: _____ Exp. Date: _____ Contribute CC Fee 2.6%: Yes No

Billing Address:

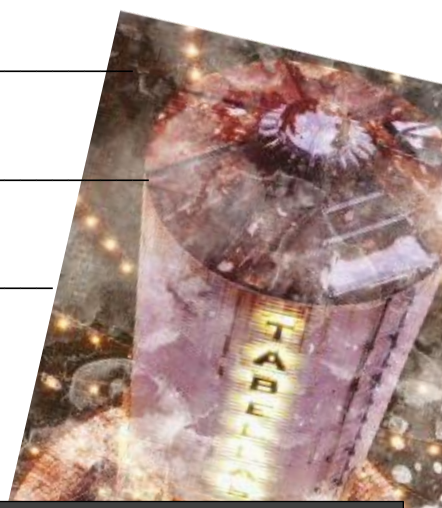
City, State, Zip

Cardholder Signature:

For more information or additional opportunities please contact:

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813-321.7781

Kelly Bustin
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kbreeding@artherapyintl.org
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**Please email this completed form to bravebash@artherapyintl.org or mail to:
ART International Training & Research - 1511 N. Westshore Blvd., Suite 750 - Tampa, FL 33607**

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