2024-2025 Advisory Board Pledge Form

CONTRIBUTOR INFORMATION

◯ Mr. & Mrs. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. ◯ Other ____

Name(s) ______________________________

Address ______________________________

City ______________________________

State ______________ Zip ______________

Phone ______________ Email ______________

◯ Please list my/our name(s) as: ______________

◯ I/We wish this gift to remain anonymous.

Designation: ◯ Friends of BrainHealth ◯ General Fund
◯ Other ______________

ANNUAL MEMBERSHIP OPPORTUNITIES

◯ $25,000 Visionary Friend

◯ $10,000 Distinguished Friend

◯ $5,000 Esteemed Friend

◯ $2,500 Special Friend

◯ $1,000 Friend

◯ $500 Companion

◯ I / We cannot commit to a Friends of BrainHealth membership but would like to give a gift of:

$ ______________

PAYMENT OPTIONS

◯ One-time donation

◯ Monthly installments

◯ Quarterly installments

MATCHING CONTRIBUTIONS

◯ My employer matches donations, please contact me at the number above.

PLANNED GIVING

◯ Please send me information about planned giving opportunities.

METHOD OF PAYMENT

◯ Check made payable to Center for BrainHealth

◯ Online donation at ***www.centerforbrainhealth.org***

◯ Contact me for credit card information

TAX INFORMATION

◯ I/We would like to DECLINE all benefits and receive a FULL TAX DEDUCTION. You will receive a receipt stating the tax-deductible amount of your gift. Tangible membership benefits are considered non-tax deductible.

By signing below, I/we are pledging the donation as shown above to Center for BrainHealth between 9/1/2024 and 8/31/25:

Signature ______________________________ Date______________________________