



Pledge Form

Through pledges, you can help us raise more money to benefit the Family Health Partnership Clinic Breast Cancer Fund. Please bring your pledges on race day or mail them to this address (PLEASE DO NOT MAIL CASH) Please make checks payable to FHPC:

**Family Health Partnership Clinic, Attn: Finance
401 E Congress Pkwy.
Crystal Lake IL 60014**

Participant Name/Team: _____ Phone _____

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

Name: _____ \$ _____

Address: _____

City, State _____ ZIP _____

Please add me to your mailing list.

TOTAL AMOUNT PLEDGED \$ _____

For donation questions, please contact Carrie Holtz, 779-330-9303 choltz@hpclinic.org.

Donor information will not be shared and is only used for acknowledgement purposes.