

Pledge Form



progressive health center

Connecting Complementary Therapies with Conventional Medicine

Donor Information (please print or type)

Name	
Billing address	
City	
State	
ZIP Code	
Telephone (home)	
Telephone (business)	
Fax	
E-Mail	

Pledge Information

I (we) pledge a total of \$_____ to be paid:
____ now ____ monthly ____ quarterly ____ yearly.

I (we) plan to make this contribution in the form of:
____ cash ____ check ____ credit card ____ other.

Credit card type		
Credit card number		CID (3 digit number):
Expiration date		
Authorized signature		

Gift will be matched by _____ (company/family/foundation).
____ Form enclosed ____ Form will be forwarded

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

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____ I (we) wish to have our gift remain anonymous.

Signature(s)
Date

Please make checks, corporate matches, or other gifts payable to: Progress Health Center

MAIL TO:

Progress Health Center
701 E. Hampden Ave. Suite 225
Englewood, CO 80113

Phone: 303-788-9399

Thank you for your support!