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\_\_\_\_\_ I accept your invitation to become a member of the Samaritan Club of the Commonwealth Health Foundation. Please enroll me with my contribution of:

\$\_\_\_\_\_ Gold Membership (\$500+ per year)

\$\_\_\_\_\_ Silver Membership (\$250 - \$499 per year)

\$\_\_\_\_\_ Bronze Membership (\$100 - \$249 per year)

Payment of \$\_\_\_\_\_ enclosed.

Signature \_\_\_\_\_

Donor Name(s) \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone ( \_\_\_\_ ) \_\_\_\_\_

Please print name(s) exactly as you wish for recognition purposes:

\_\_\_\_\_  
*(For example: Mary and John Smith; Mr. & Mrs. John Smith; Mary Smith, M.D.)*

How (or from whom) did you hear about the Samaritan Club?

\_\_\_\_\_

*Please make your check payable to the Commonwealth Health Foundation and return with the completed enrollment form to:*

Commonwealth Health Foundation  
800 Park Street  
P.O. Box 1868  
Bowling Green, KY 42102-1868

