The Circle of Women's Health Philanthropists
New Member Form

MEMBER INFORMATION

Name **First** _____ **Middle Initial** ____ **Last** _____

Address _____

City/State/Zip _____

Home Phone _____ **Cell Phone** _____

Please circle preferred phone number

Home E-mail _____ **Work E-mail** _____

Please circle preferred e-mail address

Birthday **Month** _____ **Date** _____ **Year** _____

Company _____

Title _____

MEMBERSHIP DIRECTORY OPT-IN

The Women's Circle of Health Philanthropists is creating an annual membership directory to make it easier for members to stay connected. It is available only to members of The Circle and will not be used for marketing or other mass/group promotions whose purpose extends beyond The Circle.

☐ **YES. Please include my information in The Circle of Women's Health Philanthropists Membership Directory.**

☐ **NO. Please do not include my information in The Circle of Women's Health Philanthropists Membership Directory.**

SPOUSE INFORMATION

Name **First** _____ **Middle Initial** ___ **Last** _____

Address _____

City/State/Zip _____

Phone _____ **E-mail** _____

Birthday **Month** _____ **Date** _____ **Year** _____

MEMBERSHIP

PAYMENT LEVEL ***(please select one):***

☐ **Annual Member:** I wish to become an *Annual Member* by making a yearly $2,500 commitment to The Circle.

☐ **Young Professional Member (under 40 years old):** I wish to become a *Young Professional Member* by making a yearly $1,000 commitment to The Circle.

COMMITMENT LEVEL ***(optional):***

☐ **Patroness (4-Year Society):** I wish to become a *Patroness Member* by making a 4-year commitment to The Circle.

☐ **Marie Lawson Society (10-Year Society):** I wish to join the Marie Lawson Society by making a 10-year commitment to The Circle.

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PAYMENT OPTIONS

☐ **CHECK** Enclosed is a check in the amount of $_____. Checks payable to ***Summa Health Foundation***.

☐ **CREDIT CARD** ☐ American Express ☐ Discover ☐ MasterCard ☐ VISA **Charge Amount $_____**

Please automatically charge my account:

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Account #		**Expiration Date**	
Name as it appears on credit card			

☐ **MARKETABLE SECURITIES** I would like to arrange a direct transfer of stock for my membership payment.
Please contact Summa Health Foundation at (330) 375-3159 for transfer instructions.

☐ **EMPLOYER GIFT** My employer will make my donation.

☐ **EMPLOYEE MATCHING GIFT** My employer will match my donation or a portion of my donation.

☐ **SUMMA HEALTH SYSTEM PAYROLL DEDUCTION:**

Employee ID Number:_____ Total Payroll Gift Amount: $_____

Begin Date:_____ End Date:_____

SIGNATURE REQUIRED for credit card, payroll deduction and pledges:

Member Signature: _____ Date: _____

HOW YOU LEARNED ABOUT THE CIRCLE

_____

PUBLICATION RECOGNITION

☐ Please list my name for donor recognition purposes, in Summa Health publications, specifically as follows:

_____

Please type or print

☐ I wish to remain anonymous

Thank You for your support of The Circle!

CONTACT INFORMATION:
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