COLLIE HEALTH FOUNDATION MEMBERSHIP REMITTANCE AND CONTRIBUTION FORM

PLEASE INDICATE: ___new member OR ___renewal membership

Please check level of membership desired:

__ Individual Membership	-	$ 25
__ Family Membership	-	$ 40
__ Sustaining Membership	-	$ 100
__ Patron	-	$ 500
__ Benefactor	-	$1,000

I'm interested in volunteering:

__ Promotions __ Sunnybank
__ Auctions __Newsletter

__ Other: ________________________________

Send your check (US funds only), payable to Collie Health Foundation or CHF to:

Gail Currie – CHF Membership
16150 Bonzai Trail
Brooksville, FL 34613

PAYPAL: membership@colliehealth.org

Name (as you wish to be listed): ____

Address: ____

City: ______________________ State: ______________ Zip: __________

Phone: ______________________ Kennel Name: ______________________

Email: ____

__ Please check if this is a new address.
__ I have included CHF in my will.
__ Please send me information about including CHF in my will.

Do you or your spouse work for a matching gift company? Some companies will match gifts of employees and/or retirees. Please contact your personnel office for details and a matching gift form.

Company Name: ____
Form Enclosed: __ Yes __ No

ADDITIONAL CONTRIBUTION (circle one:) in Memory, Celebration, Honoring:

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Contributions are tax deductible in accordance with IRS regulations.