



14th Annual

THE DR. PHILLIP O'SHAUGHNESSY

WALK/RUN FOR HEALTH

SUPPORTERS FORM

JULY 21, 2012
FOSTER PARK PAVILION #1

SUPPORTER GIFTS

A Supporter is one who wishes to contribute but is not running/walking, or is a business sponsor.

Clinic Week	\$40,440
Clinic Day	\$8,088
Clinic Half-day	\$4,044
Clinic One Hour	\$1011
Single Patient visit	\$60
Other _____	\$ _____

For listing on race materials, pledge level should be at least for one hour and is due by June 3. Donations can be given at any time and are greatly appreciated.

Matthew 25 Health and Dental Clinic has been providing free health care services to uninsured Allen County residents for over 30 years. We have been able to sustain the clinic because the community has been so supportive. Support comes in the form of thousands of hours of volunteer time. Our volunteers include physicians, dentists, nurses, dental hygienists, dental assistants, front desk assistants, clerical help, medicine processors and data entry in the Patient Assistance Program. Support also comes in the form of financial resources. Matthew 25 does not and never has received any governmental monies such as Medicare or Medicaid. All revenues come from donations, grants, and fund raisers. Fund raising expenses for this event are 4%, therefore 96% of the monies raised stays in our community to provide care for the uninsured.

As many of our neighbors find themselves without jobs, the unemployed become the uninsured. People who have had access to health insurance for many years are suddenly finding themselves in need of Matthew 25 services. Please consider supporting this fund raising event.

Complete the support form below and mail it to

Matthew 25 Health and Dental Clinic
413 East Jefferson Boulevard, Fort Wayne, IN 46802
Phone: (260) 426-3250, ext 215 Fax: (260) 426-0443
email: donor@matthew25online.org

PLEDGE CARD *Please complete, clip and return to above address*

Yes, I/we will support the Dr. Phillip O'Shaughnessy Walk/Run For Health benefiting Matthew 25 Health and Dental Clinic with a pledge of \$ _____

Check Enclosed for _____ Bill Me Visa Mastercard

If credit card: Card Number: _____ Expiration Date: _____

Signature: _____ Date _____

Name: _____ Business Name _____

Address: _____ Address 2 _____

City: _____ State: _____ Zip code: _____

Phone: _____ Preferred email _____