



Sponsorship Agreement

FOR OFFICE USE ONLY:

**Proceeds from Gala XIV will benefit purchase of the Da Vinci
Robotical System, allowing the hospital to offer laproscopic and
robotically assisted minimally invasive surgeries.**

April 22, 2023

Name _____
(Print name of business/organization/individuals how you prefer it to be listed for recognition purposes.)

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____

Please check one of the following categories:

\$10,000+ RADIANT

- 2 tables of 10 each at the Gala - premier, priority seating
- 20 tickets to the Benefactor's Reception prior to the main event
- Prominent recognition: printed materials, programs, advertisements, website, social media, and at the event

\$5,000+ DAZZLE

- 1 table of 10 at the Gala - priority seating
- 10 tickets to the Benefactor's Reception prior to the main event
- Prominent recognition: printed materials, programs, advertisements, website, social media, and at the event

\$2,500+ SPARKLE

- 1 table of 8 at the Gala - priority seating
- 8 tickets to the Benefactor's Reception prior to the main event
- Recognition: printed materials, programs, advertisements, website, social media, and at the event

\$1,500+ GLITTER

- 4 tickets to Gala - reserved seating with table recognition
- 4 tickets to the Benefactor's Reception prior to the main event
- Recognition: printed materials, programs, advertisements, website, social media, and at the event

\$500+ SHIMMER

- 2 tickets to Gala - reserved seating with table recognition
- 2 tickets to the Benefactor's Reception prior to the main event
- Recognition: printed materials, programs, advertisements, website, social media, and at the event

*Please list the names of guests that will be seated at your sponsorship table: **Each sponsorship package indicates the number of tickets/guests included (see left).***

*I will purchase individual Gala tickets at \$150 each.
Number of tickets _____ Total \$_____.*

I am unable to attend but would like to offer my tax-deductible donation of \$_____.

Return Form by March 31st, 2023 to:
DeWitt Medical Foundation
615 N. Esplanade • Cuero, Texas 77954

Phone: 361-524-6103 • Fax: 361-275-8970

Email: nlantz@cuerohospital.org

Enclosed is my check for \$ _____.

Please charge my:

Visa
 MasterCard
 Discover
 American Express

Account # _____

Exp. date _____ Security Code _____

Zipcode _____

Signature _____

Date _____ Phone Number _____