

**Walter Jones Memorial Pharmacy
Student Financial Aid Fund
2010 Support Opportunities**

Supporter Information

Company Name	_____		
Contact	_____		
Title	_____		
Address	_____		
City	_____	State _____	ZIP _____
Phone	_____	Fax	_____
E-mail	_____		

Support Levels

- | | |
|---|---------|
| <input type="checkbox"/> Platinum Level | \$5,000 |
| <input type="checkbox"/> Gold Level | \$3,000 |
| <input type="checkbox"/> Silver Level | \$1,500 |
| <input type="checkbox"/> Bronze Level | \$1,000 |
| <input type="checkbox"/> Crystal Level | \$750 |

Method of Payment

- Check enclosed for full amount (made payable to **ASHP Foundation**)
- Please send an invoice (Note: Full payment must be received by **September 3, 2010.**)
- Please charge to my: Visa MasterCard
 Discover American Express

Account # _____

Exp. Date _____

Signature _____

*Please return completed form, along with form of payment or request for an invoice, **no later than September 3, 2010:**
Bethany Coulter, ASHP Foundation, 7272 Wisconsin Avenue, Bethesda, MD 20814; by e-mail to bcoulter@ashp.org; or
fax to 301-664-8895.*