



## Rhythm of the Nights - Partnership Form

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

We would like to support the fall event as follows:

- ☐ Champion - \$30,000      ☐ Hope Giver - \$15,000      ☐ Advocate - \$10,000  
☐ Heartbeat - \$5,000      ☐ Love - \$3,500

Heartbeat Supporters:

- ☐ Entertainment - \$5,000    ☐ Flowers - \$3,000    ☐ Reception - \$2,500  
☐ Photography - \$2,000    ☐ Wine - \$1,500    ☐ Valet - \$1,000  
☐ *Sorry, I am unable to participate, but my donation of \$ \_\_\_\_\_ is enclosed*

☐ Enclosed is my check for \$ \_\_\_\_\_  
*(Please make checks payable to BMH Foundation)*

☐ Charge my credit card for \$ \_\_\_\_\_

☐ American Express      ☐ MasterCard      ☐ Discover      ☐ Visa

Name as it appears on the card: \_\_\_\_\_

Card No.: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVV: \_\_\_\_\_

Signature: \_\_\_\_\_

*Please return this form to: BMH Foundation • PO Box 2401, Bakersfield CA 93303*

*For more information email: [contactbmhf@dignityhealth.org](mailto:contactbmhf@dignityhealth.org) or call 661-541-0190*

**Tax ID #95-3555043**