

**Spirit of Medicine Campaign
Donation/Pledge Form
(Please print clearly)**

Yes, I want to support CPHP's mission of assisting Colorado physicians, residents, medical students, physician assistants and physician assistant students who may have health problems, which if left untreated, could adversely effect their ability to practice medicine safely.

Prefix:
(i.e., Dr., Ms., Mrs., Mr., Rev., Rabbi, Hon., etc.)

Suffix:
(i.e., M.D., D.O., PhD., Esq., etc.)

First Name:

Middle Initial:

Last Name:

Organization:

Address:

City:

State:

Zip: -

Home phone:

Work phone:

E-mail:

Donation type (check all that apply):

- Single gift to CPHP's **Spirit of Medicine Campaign** in the amount of:
 \$1,000 \$500 \$250* \$100 \$50 \$25 Other: \$_____

*A \$250 donation represents the monthly cost of monitoring a CPHP participant's treatment

LivingWell Giving Society:

- \$2,500 per year for 5 years
This represents the cost of a comprehensive diagnostic evaluation for a Physician, Physician-in-Training, or Physician Assistant.
- \$10,000 per year for 5 years
This represents the cost of an annual Physician Health Community Symposium.
- \$25,000 per year for 5 years
This represents the cost of a Physician Health Workplace Training Series.
- \$50,000 per year for 5 years

This represents the cost of an additional clinical staff person to expand CPHP services in areas such as improved outreach and education across Colorado.

- Eternal Life Legacy Program:**
 - will/bequest
 - life insurance
 - trust
 - stock
 - annuity
 - property

- In-kind donation/volunteer technical support. After viewing [CPHP's Wish List](#), please contact CPHP's Development Specialist who coordinates the ***Spirit of Medicine Campaign*** at (303) 860-0122 or (800) 927-0122 to discuss the item(s) you wish to donate and/or to discuss volunteer opportunities.

Tribute gift:

Please make my gift in:

honor of: _____ memory of: _____

Send acknowledgment card to:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____ - _____

Sign card from: _____

Gift Matching:

My workplace will match my contribution: Yes No

Name of workplace: _____

Gift Recognition:

I/We prefer to be recognized by: (choose one)

Name: _____

Practice/Organization: _____

Please do **not** publish my name or practice as a donor (check only if you do not want recognition of any kind)

Keep a copy of this form and mail original to:

Spirit of Medicine Campaign

Colorado Physician Health Program

899 Logan Street, Suite 410

Denver, CO 80203-3156

Thank you for your generous support and commitment to CPHP's mission!

