

Name _____

Spouse/Partner/Contact Name _____

Company Name (if applicable) _____

Address _____

Primary Phone Number _____ Work Phone Number _____

Email _____

I hereby allow Headwaters Health Care Foundation to share my contact information with other Innovator Members and the Innovators Steering Committee

Pledge Information

I/We would like to sign up for Innovators 20/21 as:

- An Individual | \$2,500
- A Couple | \$4000
- A Corporate Member | \$3,000

I/We will honour this pledge now monthly quarterly

Payment Options

Cheque made payable to Headwaters Health Care Foundation

Credit Card

Card No. _____ Exp. _____ / _____

Signature _____ Date _____

I understand that my gift will be processed on the 15th of the month.

Pre-Authorized Payment

I authorize Headwaters Health Care Foundation to deduct \$_____ from my account on the 15th of the month until my pledge is fulfilled. **Please attach a cheque marked VOID.**

I understand that Innovators runs from April 2020 to March 2021

I have read and understand the Innovators Terms of Reference.

Signature

Date

If you know of any businesses or individuals who may be a great Innovator, please put their details below and the Foundation will follow up with them.

Name _____ Phone/Email _____

Name _____ Phone/Email _____

Name _____ Phone/Email _____

Name _____ Phone/Email _____