



PRESIDENT'S COUNCIL MEMBERSHIP FORM

Name: _____ Spouse Name: _____
 Address: _____
 Cell Phone: _____ Spouse Cell Phone: _____
 Email: _____ Spouse Email: _____

MEMBERSHIP LISTING _____
(As you wish it to appear in publication)

PRESIDENT'S COUNCIL DESIGNATION *(Choose one)*

- Unrestricted Dentistry Graduate Health Professions Medicine Nursing Laredo South Texas

PAYMENT OPTIONS

- Check payable to UT Health San Antonio with the President's Council notation.

CREDIT CARD AUTHORIZATION *(Choose one)*

Please charge my credit card:

- Annually: \$1,000 \$2,500 \$5,000 \$10,000
 Quarterly: \$250 \$625 \$1,250 \$2,500

Cardholder Name: _____ Expiration Date: _____
 Credit Card Number: _____ Security Code #: _____

I authorize UT Health San Antonio to initiate charges to my credit card as indicated above. This will remain in effect until UT Health has received written notification from me of its termination. I understand payments are recurring gifts that continue until written notice is received from me.

Signature: _____ Date: _____

PAYROLL DEDUCTION AUTHORIZATION *(For UT Health San Antonio Faculty and Staff)*

- \$1,000 (\$85/month) \$2,500 (\$210/month) \$5,000 (\$420/month)

I authorize UT Health San Antonio to initiate the monthly payroll gift deduction as indicated above. I understand payroll deduction payments are recurring gifts that continue monthly until written notice is received from me or my employment terminates.

Signature: _____ Date: _____

- I would like to make a donation in Honor Memory of _____
 Please notify the following of my gift:

Name: _____ Phone: _____
 Address: _____

Please email your form to Gift Processing at: GiftProcessing@uthscsa.edu or mail it to the address below.

PEOPLE. PASSION. PURPOSE.