




















2021 Healthcare Justice Awards Sponsorship Packet

	Platinum Doctorate Scholar	Gold Practitioner Scholar	Silver BS Nursing Scholar	Bronze Medical Asst. Scholar	Student Preceptor Scholar
Sponsor Benefits					
Cost	\$15,000	\$10,000	\$5,000	\$2,500	\$1000
Table(s)					
Website listing & Online marketing*					
Swag bag item					
Marketing materials**					
Ad in event program†	Full page	Full page	Half page	Quarter page	
Acknowledgement from stage					
Presentation of award					

*Listing on PrimaryOne Health website, on social media and online advertising. (\$100 value)

** Marketing materials may include, but aren't limited to, Save the Date cards (dependent date of receipt), Invitations, listed on ads in Columbus African American News Journal, and logo listing in 2021 Annual Report (\$150 value)

†Event Program Ad values vary in pricing based on size (\$50-\$200 value)

Swag bags will be distributed to approximately 300 event attendees.

First Name: _____ Last Name: _____
 Organization: _____ Title: _____
 Street Address: _____
 City: _____ State _____ Zip _____
 Phone: _____ Fax _____
 Email: _____
 Signature: _____

Please select your tax-deductible sponsorship

<input type="checkbox"/>	\$15,000 Doctorate Sponsor	<input type="checkbox"/>	\$10,000 Practitioner Sponsor	<input type="checkbox"/>	\$5,000 BSN Sponsor
<input type="checkbox"/>	\$2,500 Scholar Sponsor	<input type="checkbox"/>	\$1,000 Student Sponsor	<input type="checkbox"/>	\$100 Individual Ticket

Check here if interested in hybrid option

_____ Number of Tickets
 _____ Total Amount

\$50 tax-deductible contribution per individual ticket. Total tax deduction amount varies per sponsorship package

Payment Type:

- Invoice/Check (Payable to PrimaryOne Health)
- Online Payment, visit
- Credit Card

Name: _____
 Card Number _____ Exp. Date: ____/____
 Billing Address, if different from above _____

Please mail this form with your check to:
PrimaryOne Health, PO Box 16370, Columbus, OH 43216-6370