



Inova is recognized and committed to having the best-trained and motivated workforce possible! Nursing Stars sponsorships extend continuing education opportunities to even more nurses, allowing the benefits of your gift to be experienced for years!

Your star/s will receive recognition letting them know you've honored them, as well as this year's special nursing star-shaped lapel pin.

## Sponsorship Levels:

- ★ \$1,000 for a patient care unit
- ★ \$50 per star

## Complete Sponsorship:

**Online:** [www.inova.org/nursingstars](http://www.inova.org/nursingstars) **Email:** [Foundation@inova.org](mailto:Foundation@inova.org)

**Mail:** Inova Health Foundation **Phone:** (703) 289-2094  
 Attn: Nursing Stars  
 8110 Gatehouse Road, Suite 200E  
 Falls Church, VA 22042

I do not wish to name a nurse. However, please accept this donation of \$ \_\_\_\_\_ for the Nursing Stars program.

## 1 Sponsor Information

**Print sponsor name as you would like it to appear in Foundation acknowledgements.**

Contact person for billing purposes:

Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

## 2 Information About Your Nursing Star(s)

This gift is  in honor  in memory of \_\_\_\_\_ at \_\_\_\_\_  
 Nurse Name or Patient Care Unit Name Hospital/Unit

Please check if the nurse listed above is employed at Inova. If not, please provide contact information below so that we may send a letter acknowledging your gift:

Name \_\_\_\_\_

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

This gift is  in honor  in memory of \_\_\_\_\_ at \_\_\_\_\_  
 Nurse Name or Patient Care Unit Name Hospital/Unit

Please check if the nurse listed above is employed at Inova. If not, please provide contact information below so that we may send a letter acknowledging your gift:

Name \_\_\_\_\_

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

*For additional stars, please use a separate piece of paper.*

## 3 Payment Information

For internal use only

**Cash, Check, Pledge or Charge** Please make your check payable to **Inova Health Foundation** and return with this form.

**Cash or Check** Enclosed is my gift in the amount of \$ \_\_\_\_\_

**Pledge** My 2021 pledge of \$ \_\_\_\_\_ will be paid in the following manner by December 31, 2021:

To be paid in  two  three  four monthly installments

Signature (if using a credit card) \_\_\_\_\_

Please charge my credit card  MasterCard  VISA  AMEX Exp. Date \_\_\_\_\_

Account No. \_\_\_\_\_

