Annual Corporate Supporter Application
2017

Name of Company: _____

Name of Contact/ Representative: _____

Title: _____

Address: _____

City, State Zip: _____

Telephone/Fax: ___(____)_____ / ___(____)_____

Email address: _____

Signature: _____ Date: _____

$500.00 Corporate Supporter – One Year

Please return application via mail, fax or email by to:

American Dental Hygienists' Association
Institute for Oral Health
444 N. Michigan Ave, Suite 400
Chicago, IL 60611
Fax: (312) 467-1806
Email: maddieh@adha.net

Payment Type: ❑ Invoice ❑ Check Enclosed

❑ Visa ❑ MasterCard ❑ Amex ❑ Discover

NOTE: a 3% processing fee will be charged for all credit card payments

Credit Card Number _____ Expiration Date _____V-code:_____

Authorized Signature _____

Please make check payable to the ADHA Institute for Oral Health.

Note: Contributions to the ADHA Institute for Oral Health are deductible for federal income tax purposes.

Once your donation is processed, you will be contacted and asked to send your company logo and web link to be placed on the ADHA & IOH websites.