Sponsorship Request Form

Name: _____

Parent Name (if under 18): _____

Are you a current or past Dr. West patient: Yes No

Phone number: _____

Email: _____

Sponsorship Request:

- ☐ Dollar Donation | Amount: _____
  - Make check payable to: _____
  - Ad dimensions (if applicable): _____
- ☐ Discounted Treatment
- ☐ Other: _____

_____

_____

School/Organization Name: _____

Due Date: _____

Special Requests and Comments: _____

_____

_____

_____

_____