

The 17th Annual Northern Nevada Dental Health Programs /
Joel F. Glover, DDS Charity Golf Tournament 2019

Benefiting the Underserved in our Community. Non-profit tax ID #88-0411192

Place: LakeRidge Golf Club, Reno **Date:** Friday, September 20, 2019
Times: 7:00 a.m. ~ Breakfast & Golfer Check-In / 7:45 a.m. ~ Shotgun Start/Tee Time
1:00 p.m. (est. time after golf) ~ BBQ Lunch, Hosted Beer, Raffle Winners & Awards

Format: Scramble

Mulligans: available for purchase at tournament

Sponsorship/Participation Opportunities

MAJOR SPONSOR **\$5,000**

- ❖ Your Company name/logo prominently advertised on golfer's gift
- ❖ Pre- and post-event publicity including social media
- ❖ Special recognition during tournament and award BBQ
- ❖ Tee Signage including invitation for company representation on course
- ❖ One (1) foursome reservation to play

HOLE / TEE SPONSOR **\$1,950**

- ❖ Your company name/logo on Tournament golfer's program and signage
- ❖ Special recognition during tournament, award BBQ, and social media
- ❖ Tee Signage including invitation for company representation on course
- ❖ One (1) foursome reservation to play

FOURSOME: **\$ 990** **BREAKFAST SPONSOR:** **\$1,100**

INDIVIDUAL ENTRY TO PLAY: **\$ 275** **BBQ LUNCH SPONSOR:** **\$1,800**

HOLE SPONSOR ONLY: **\$ 550** **HOLE-IN-ONE SPONSOR** contact us for details
❖ Name on Signage: _____

FRIENDS OF NNDHP GIFT: **\$ 250** **ADDITIONAL GUEST FOR BBQ** **\$ 40**
(can't attend tournament but want to support) (we welcome spouses/friends/family to join you at BBQ)

Team/Player Registration

(All are welcome: Singles, Twosomes, Foursomes or we'll pair you up)

TEAM (SPONSOR'S) NAME: _____

Golfer #1 _____

Email: _____

Phone: _____

Golfer #2 _____

Email: _____

Phone: _____

Golfer #3 _____

Email: _____

Phone: _____

Golfer #4 _____

Email: _____

Phone: _____

*If you have a team pairing preference please state: _____

I am able to participate this year please enter us in the above circled entry:
OR I am unable to participate but would like to sponsor the above circled level:

TOTAL AMOUNT ENCLOSED \$ _____ (Check, Visa, MasterCard, Discover, or Amer Xpress)

_____ Exp. Date: ____ / ____

Sec. code: _____ Statement Zipcode: _____ Name on Card: _____

Send to: Northern Nevada Dental Health Programs, 5605 Riggins Court, Suite #101A, Reno, NV 89502,
O: (775) 337-0296, or **FAX to: (775) 337-0298** or **email: nnds@nndental.org / www.nndhp.org**