TOTAL DENTAL CARE
REQUEST FOR SPONSORSHIP OR DONATION

Your name _____ Date of request _____

Organization requesting funds _____

Amount requested _____ Date funds needed _____

Your phone _____ email _____

If minor, Parent's name _____ Phone_____

Are you a patient of Total Dental Care? _____

**While we wish we could say "yes" to every request for financial support, we must limit our support to requests made by patients of our practice. Thank you for your understanding in this matter.*