ATS Student Nursing Walkathon

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ (Grade Level) _____

Teacher's Name _____

Donation Due Date: _____

Sponsor Instructions

- Print the amount of your donation, along with your name, address, city and zip code.
- Checks should be made payable to the participant. Your cancelled check is your receipt.
- Please be generous! Remember, your donation will help Health Occupation Students of America.

Sponsor's Name	Address / or / Phone Number	Donation Per LAP		Amount Collected	
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Total Amount Collected $ _____