## Kingdom Partnership Request Form

Thank you for your interest in becoming a Kingdom Partner with Christian Therapeutic Ministry. Please complete the form below to begin the partnership process. A member of our team will contact you shortly.

### Organization/Church/Business Information

Name of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Type of Organization

□ Church □ Ministry □ Business □ Nonprofit □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Services Requested (Check all that apply)

□ Pastoral/Spiritual Counseling  
□ Holistic Health Webinar/Training  
□ Resiliency Training  
□ Evangelism or Leadership Training  
□ Ministry Consulting  
□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Partnership Commitment

Please indicate how your organization intends to support the Orphan Care Mission:

□ Monthly Financial Contribution  
□ One-time Donation  
□ In-kind Support/Resources  
□ Volunteer Support  
□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

### Additional Notes or Comments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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### Authorization

I certify that the information provided is accurate and that our organization is interested in establishing a Kingdom Partnership with Christian Therapeutic Ministry. We understand the mutual commitment and agree to the spirit of collaboration and support outlined in CTM’s mission.

Authorized Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_