

29th Annual Trustmark Friends of Children's Hospital Golf Tournament

Schedule of Events

***Golf Practice Rounds are available beginning the week prior. Tee times can be scheduled around member play at each of the courses – Annandale, Reunion and Country Club of Jackson (Each course is limited to 22 teams)**

Monday, October 17, 2022

11:00 a.m. – Registration begins at each Clubhouse/Golf Shop and Practice Ranges open
12:30 p.m. – Shotgun Start for Trustmark Friends of Children's Hospital Golf Tournament
Lunch Provided at all courses at 11:30 a.m. *Awards following play on all courses

Please mail completed entry form with payment to:
Friends of Children's Hospital | 3900 Lakeland Drive | Suite 205 | Flowood, MS 39232
or scan and email to lesliecampbell@friendsofch.org

<u>Name</u>	<u>Handicap</u>	<u>Club Affiliation / GHIN #</u> (Handicaps will be verified)
Player 1 _____	_____	_____
Player 2 _____	_____	_____
Player 3 _____	_____	_____
Player 4 _____	_____	_____
Player 5 or Pro _____	_____	_____

*Alternatively, you may elect to bring your own PGA Professional as one of your five players (no more than one pro per team).

Team Captain / Contact Person _____ Phone _____

Address _____

City _____ State _____ Zip _____

Email Address _____

****All future correspondence will be sent to the team captain via email**

Please Check

- | | | |
|---|---|------------------|
| <input type="checkbox"/> Monday Tournament Entry (5 player team) | = | <u>\$1500.00</u> |
| <input type="checkbox"/> Team Skins Game Entry (\$200 / team) | = | _____ |
| <input type="checkbox"/> Tournament Mulligans (\$150 / team) | = | _____ |
| <input type="checkbox"/> Priority Hole Option (\$1,000 for No. 1 or \$500 for No. 10) | = | _____ |
| Desired course: _____ Desired Hole: _____ | | |

Total Due: _____

PLEASE RANK COURSE PREFERENCE – The first 18 teams to designate a course will be guaranteed their preference.

____ Annandale Golf Course ____ Country Club of Jackson ____ Reunion Golf Course

Please include charge information or attach your check payable to Friends of Children's Hospital

Name on Card: _____ Card Number: _____

Exp. Date: _____ CVV Code: _____ Signature of Cardholder: _____