

Now more than ever...

St. Elizabeth Hospital Foundation DONATION FORM

Yes, I want to support the mission of St. Elizabeth Hospital

Please accept my gift in the amount of:

\$2,500 \$1,000 \$500 \$250 \$100 \$_____

Please direct my gift to:

- Calumet Medical Center Cancer Fund Other _____
 Heart & Lung Fund Needs of the Poor and Underserved Fund (Name of fund)
 Women & Families Fund Where the Need is Greatest (unrestricted)

In memory/honor of: _____

- Please list me/us in any recognition materials as: _____
 I would like to remain anonymous.
 I/we have included the St. Elizabeth Hospital Foundation in my/our will.
 Please send information about gifts that I provide income to the donor.
 My employer has a matching gift program, please call me to discuss.

I will make my gift by:

- Check** Please make payable to **St. Elizabeth Hospital Foundation**
- Credit Card** Please process my charge payment(s) of: \$_____
- one-time monthly quarterly annually
- Start date: ____/____/____ VISA MasterCard Discover AmEx
- Card # _____-_____-_____-_____ Exp. Date: _____
- Pledge** Please bill me payment(s) of: \$_____
- one-time monthly quarterly annually
- Start date: ____/____/____ for internal purposes only

Name(s) _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Phone _____

Signature Required: _____ **Date:** _____

Information provided to St. Elizabeth Hospital Foundation is kept in the strictest of confidence. Please contact us at (920) 831-1475, or write us at 1506 S. Oneida St., Appleton, WI 54915, if you wish to have your name removed from future fundraising requests. Upon notification, all reasonable effort will be taken to adhere to your wishes. **All gifts to St. Elizabeth Hospital Foundation are tax deductible to the extent permitted by law.**

Thank you for your generosity.

Please return form to:

St. Elizabeth Hospital Foundation
1506 S. Oneida St. | Appleton, WI 54915-1397



www.affinityhealth.org/STEFoundation