

Memorial Hospital Foundation Donor Card

Enclosed you will find my gift of \$ _____

Please use this gift:

- Where it is needed most
- Other _____

Donor information

Name _____ Address _____

City _____ State _____ Zip _____

Phone Number _____ Email Address _____

- Please do not publish my name, I wish to remain anonymous.
- I am able to increase the level of my gift through a Matching Gift Program from my or my spouse's employer. (Please include matching gift form.)

Payment options

Make checks payable to the Memorial Hospital Foundation, establish a payment plan or complete the following credit card information:

Credit Card Type:

- VISA
- MasterCard
- Discover

Credit Card # _____ Expiration date _____ Signature _____

I authorize you to charge my credit card:

- Monthly
- Quarterly
- Annually

In the amount of \$ _____ for a total of \$ _____

Payment plan

Please bill me:

- Monthly
- Quarterly
- Annually

Start Date _____ Payment Total \$ _____

- Please contact me about automatic checking account deductions on a schedule that I agree upon (Electronic Fund Transfers).

In memory or honor

My gift is in:

- Honor of _____
- Memory of _____
- Occasion _____

Please notify:

Name _____ Address _____

City _____ State _____ Zip _____

All memorial/honor gifts are acknowledged, but the amount is kept confidential.

Create your legacy

- I have remembered Memorial Hospital Foundation in my estate plans (through a will, trust, life insurance policy, etc.)
- I would like information on how to include Memorial Hospital Foundation in my estate plans.

Return completed donor card to:
Memorial Hospital Foundation
715 S. Taft Avenue
Fremont, OH 43420