Your Gift

Donation Amount: $ ____

Donation Frequency: ❑ One-Time ❑ Annually ❑ Semi-Annually ❑ Quarterly ❑ Monthly ❑ Weekly

Fund: ❑ Annual Campaign ❑ Education Fund

Specific Hospital Departments:

❑ Pharmacy	❑ Radiology Services	❑ Wound Clinic	❑ Laboratory Services
❑ Taylor Clinic	❑ Emergency Dept	❑ Oncology Dept.	❑ Nursing Dept
❑ Cardiac Rehab	❑ Com. Medical Clinic	❑ Therapy Dept. Fund	❑ Misc. Projects

Memorial or Honorarium:

In (memory/honor) of____

Billing Address

Title (Mr, Ms, Mrs, Miss, Other): ____

Name: ____

Address:____

City:______________________________State:______________Zip Code:___________________

Email:____

Phone:____

Payment Information

Amount: $ ____

Card Type: ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Name on Card:____

Card Number:______________**Expiration Mo/Yr:**__________________**CVV:**_________________

Additional Comments:____

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**We do not sell personal information or use it for purposes other than the support of Culbertson Memorial Hospital Foundation. Once we receive your gift, we will issue your tax-deductible receipt as soon as possible.*

Culbertson Memorial Hospital Foundation board exercises prudent judgment in its stewardship responsibilities and assures donors that their gifts will be used exclusively for the purpose they designate and will not be combined with Sarah D. Culbertson Memorial Hospital operating funds. Donors are assured that information about their donations are handled with respect and confidentiality to the extent provided by law.