

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

GIFT AMOUNT: \$ _____

BECOME A MONTHLY DONOR: \$ _____ PER MONTH.
YOUR FIRST GIFT WILL BE PROCESSED TODAY, WITH FUTURE GIFTS AUTOMATICALLY PROCESSED EACH MONTH THEREAFTER.

I WOULD LIKE TO DESIGNATE MY GIFT TO A SPECIFIC FUND: _____

METHOD OF PAYMENT: _____

CHECK (PLEASE MAKE CHECKS PAYABLE TO SOUTH COUNTY HEALTH FOUNDATION)

CREDIT CARD MASTERCARD VISA AMERICAN EXPRESS

CARD NUMBER: _____ CVV NO: _____

SIGNATURE: _____ EXP. DATE: _____

:

BILLING ADDRESS (IF DIFFERENT FROM MAILING ADDRESS):

THIS GIFT IS MADE: IN MEMORY OF IN HONOR OF

NAME: _____

PLEASE SEND ACKNOWLEDGEMENT TO: _____

NAME: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

I PREFER TO MAKE THIS DONATION ANONYMOUSLY.

PLEASE SEND ME INFORMATION ABOUT:

JOINING THE CIRCLE OF CARE GIVING THROUGH MY WILL VOLUNTEER OPPORTUNITIES

I HAVE INCLUDED SOUTH COUNTY HEALTH IN MY ESTATE PLANNING.

FOR MORE INFORMATION, PLEASE CALL US AT 401-788-1492 OR FOUNDATION@SOUTHCOUNTYHEALTH.ORG

**RETURN TO:
SOUTH COUNTY HEALTH FOUNDATION
100 KENYON AVENUE
WAKEFIELD, RI 02879**