



I want to honor a special caregiver or department

Caregiver's First Name _____

Caregiver's Last name _____

or Department Name _____

Your First Name _____

Your Last Name _____

Phone Number _____

Address _____

Email _____

Comments _____

Donor Information

Name _____

Company Name (if corporate gift) _____

Address _____

City _____

State _____ Zip _____

Preferred Phone number _____

E-mail _____

Name as you wish it to appear in public recognition

I wish to remain anonymous

All donors will be recognized in Foundation publications.

Gift Information

My gift amount is \$ _____ and will be paid by:

1. One outright payment
or by pledge with payment schedule of:
2 semi-annual 4 quarterly other _____

2. By Check (enclosed) \$ _____
(payable to Parma Hospital Health Care Foundation)

3. By Credit Card \$ _____
Please charge this gift amount to my:
 VISA MASTERCARD DISCOVER
Name on Card _____
Acc't. Number _____
Exp Date _____ Security Code _____

4. Stock transfers (ask your financial advisor about the benefits of donating appreciated stock):
Please contact the Foundation at 440-743-4280 for instructions.