

## Donation Form

### Mission Hospital Foundation

Your support and engagement will significantly enhance care at Mission Hospital.

**Name:** \_\_\_\_\_

Mrs.  Ms.  Mr.  Dr.

**Company/Organization:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City/State/ZIP:** \_\_\_\_\_

**Business Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_ **Website:** \_\_\_\_\_

**As an expression of my/our support of Mission Hospital, I/we make a commitment to contribute by:**

Making a one-time gift of \$\_\_\_\_\_.

Pledging \$\_\_\_\_\_ to be paid monthly/yearly, in payments of \$\_\_\_\_\_, commencing on \_\_\_\_\_.

Please make checks payable to Mission Hospital Foundation. For credit card payments, please fill out fields below.

**Total Donation Amount: \$**\_\_\_\_\_ **Amount Included Today: \$**\_\_\_\_\_

Please send pledge reminders \_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Yearly

Please charge to my:  American Express  Master Card  Visa

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Fund: \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_

*Thank you for making a difference in the health care of our community!*

If you would prefer not to receive fundraising mail or event invitations from Mission Hospital, please call us (949) 364-7783 or check the box below and return this form and the foundation will remove your name from all future mailings.  Please remove me from your solicitation mailing lists.

\*Donor wall listings and naming opportunities are available with donations of \$10,000 and above.

Federal Tax I.D. # 95-1643360