Marshfield Clinic Health System Foundation

Marshfield Clinic Health System Foundation Donation Form

Yes, I want to make a tax-deductible gift of: $____________

Please use my gift for the following purpose:

- ❑ Area of Greatest Need
- ❑ Research
- ❑ Education
- ❑ Patient Care Needs
- ❑ The following purpose/fund: ____

Payment Information:

- ❑ My check payable to MCHS Foundation is enclosed.
- ❑ Charge my credit card.
  - ❑ Visa
  - ❑ Mastercard
  - ❑ Discover
  - ❑ American Express

____________________________________ Card Number

_______/__________ Expiration date

Tribute Gift (if applicable):

Gift is given □ *in memory* or □ *in honor of:* ____

Please notify ______________________________ ______________________________ Relationship

at the following address: ____

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Donor Information:

Name(s) ______________________________ Phone ____________________

Organization ______________________________ Email ____________________

Address ____

City ______________________________ State __________ ZIP __________

Thank you for your gift. Your support is greatly appreciated.

______________________________ Signature

____________________ Date

Please return completed form to:

Marshfield Clinic Health System Foundation, 1000 N. Oak Avenue, Marshfield, WI 54449