

FRIENDS OF SACRED HEART HOSPITAL
ONLINE DONATION FORM

DONOR INFORMATION

Name(s) _____ Phone _____
Address _____
City _____ State _____ Zip _____
Email _____ Cell Phone _____

At this time, I would like to make a one-time gift to Sacred Heart Hospital.

My check for \$ _____ made out to Friends of Sacred Heart Hospital is enclosed.

I would like to support Sacred Heart Hospital using my credit card for a one-time gift of \$ _____ (\$25 minimum)

1. Type of card (check one) Visa MasterCard Discover
2. Credit card number _____ Exp. date _____
3. Card holder signature _____

I want to help Sacred Heart Hospital, each month.

My signature authorizes Friends of Sacred Heart Hospital to charge \$ _____ (\$10 minimum) to my credit card on a monthly basis.

Indicate duration: 12 months 24 months 36 months

1. Type of card (check one) Visa MasterCard Discover
2. Credit card number _____ Exp. date _____
3. Card holder signature _____

GIFT DESIGNATION

For the area of greatest need.

For the needs of _____ program/service.

TRIBUTE GIFT INFORMATION

My gift is in Memory Honor of: _____

Please notify:

Name(s) _____

Address _____

City _____ State _____ Zip _____

Please send me extra gift envelopes.

I have named Sacred Heart Hospital in my will or estate plans.

I would like to know more about making charitable provisions in my estate plans.

I wish to remain anonymous

Every gift will be used in its entirety as designated and is tax deductible to the fullest extent by law. Specific questions regarding tax planning should be directed to your financial and/or legal advisors. Please mail this form and checks made payable to the FRIENDS OF SACRED HEART HOSPITAL, a division of the Hospital Sisters Health System of St. Francis Foundation, Inc. a not-for-profit 501(c)3 organization.

Complete and mail to:
Friends of Sacred Heart Hospital
900 W. Clairemont Ave.
Eau Claire, WI 54701



A Division of Hospital Sisters of St. Francis Foundation, Inc.