



## Donation Form

Please print this page, fill out the form below and mail, along with your tax deductible donation, to:

**White Plains Hospital Foundation, 41 East Post Road, White Plains, NY 10601**

### DONOR INFORMATION

First and Last Name: \_\_\_\_\_

Spouse First and Last Name: \_\_\_\_\_

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

City, State Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_ (Circle: Home/ Cell/ Business)

### GIFT INFORMATION

1) **Gift Amount** \$ \_\_\_\_\_

2) **Gift Purpose**  The enclosed is an **unrestricted gift** to White Plains Hospital

The enclosed is a **restricted gift** to the following program:

\_\_\_\_\_

3) **Gift Type**  CHECK (Please make checks payable to **White Plains Hospital Foundation**)

CREDIT CARD Please charge my credit card:

Name on Card: \_\_\_\_\_

Account number: \_\_\_\_\_ Exp date: \_\_\_\_\_ CSC#: \_\_\_\_\_

Authorized signature: \_\_\_\_\_ Date: \_\_\_\_\_

### HONORARY/MEMORIAL GIFT

If your gift is in honor or in memory of a special person, please fill out the additional information below.

*Please note that due to processing costs, we regret that we cannot accept honor/memorial gifts less than \$25 dollars.*

This gift is made in honor of: \_\_\_\_\_

This gift is made in memory of: \_\_\_\_\_

#### Please notify the following individual of my donation:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Thank you for supporting White Plains Hospital*

41 East Post Road • White Plains • New York • 10601 • T (914) 681-1040 • F (914) 849-2763 • www.givetowphospital.org