

A Gift to Stamford Hospital



I would like to make a gift to Stamford Hospital.

Name _____
Address _____
City, State, Zip _____
Phone Number _____
E-mail Address _____

My gift amount is \$ _____

Enclosed is my check made payable to **Stamford Hospital**.

Please charge my donation to MasterCard Visa

I would like to make a monthly credit card donation.

Please charge my monthly gift of \$ _____ to my credit card.

Credit card number _____

Name of card holder _____

Expiration date _____ / _____ / _____

Signature _____

Matching Gifts

My gifts will be matched by my current, former, or spouse's employer.

Matching gift form enclosed Form will arrive later

I would like to make a gift in honor or memory of someone.

In honor of _____

In memory of _____

Please send an honor or memory acknowledgment to:

Name _____

Address _____

City, State, Zip _____

I wish to make a gift of securities, please contact me.

Please send me information about remembering Stamford Hospital in my will.

I wish to remain anonymous.

Please do not send me information on programs and services at Stamford Hospital.

Please designate my gift for programs and services as follows:

Area of Greatest Need

Bennett Cancer Center

Cardiology

Orthopedics

Pediatrics

Rehabilitation

Technology

Women's Health

Other _____

Please print out, fill in this form and enclose with your payment.

Mail to:

*Stamford Health Foundation
9 West Broad Street, 9th Floor
Stamford, CT 06902*

You may include comments or additional information on the back of this form.