



## Donation Fax-in Form

**To:** Windber Healthcare Foundation **Fax:** (814) 467-3967 **Tel:** (814) 476-3705

**Name of Donor:** \_\_\_\_\_

**Co. Name/ Title (if applicable):** \_\_\_\_\_

**Address of Donor:** \_\_\_\_\_

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

**Telephone No.:** ( ) \_\_\_\_\_ - \_\_\_\_\_

### I would like to make my gift with:

\_\_\_\_ The enclosed cash/check (made payable to Windber Healthcare Foundation)

\_\_\_\_ The following credit card: \_\_\_\_ Visa \_\_\_\_ MasterCard \_\_\_\_ Discover \_\_\_\_ Amex

Credit Card # \_\_\_\_\_ Expiration \_\_\_\_\_

My signature \_\_\_\_\_

### Please use my gift for:

\_\_\_\_ Area of greatest need

\_\_\_\_ Specific support of \_\_\_\_\_

### Tribute Gifts

*If you are making this gift in honor or memory of someone, please complete the following:*

This gift is:

\_\_\_\_ In honor of: \_\_\_\_\_

\_\_\_\_ In memory of: \_\_\_\_\_

Please notify: Name \_\_\_\_\_

Relationship to honoree: \_\_\_\_\_

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

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

### Thank You!

A letter of acknowledgement will be sent from Windber Healthcare Foundation to the donor address listed above.