

To make a contribution to Washington Health System Foundation, please print, complete and return this donor form with your gift to:



155 Wilson Avenue, Washington, PA 15301  
724-223-3875

Please provide the following donor information:

First Name \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_

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

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

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Gift Amount \$ \_\_\_\_\_

Show my support by making this a **recurring monthly donation**

Enclosed is  My Check  Bill my Credit Card

Credit Card Type  Mastercard  Visa  Discover  American Express

Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ CSC \_\_\_\_\_

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

Signature \_\_\_\_\_

Please restrict my gift to: \_\_\_\_\_

*Please list Health System Department or Program Name, such as Children's Therapy, Palliative Care, Teen Outreach, Washington Hospital, WHS Greene, etc. **Gifts without a donor designation will be used for the Health System's "Area of Greatest Need."***

This gift is a Commemorative Gift  in Honor of  in Memory of

Honoree/Memorial's Name \_\_\_\_\_

Send Memorial Notification to:

Name \_\_\_\_\_

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

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